SEPTEMBER • OCTOBER 1963

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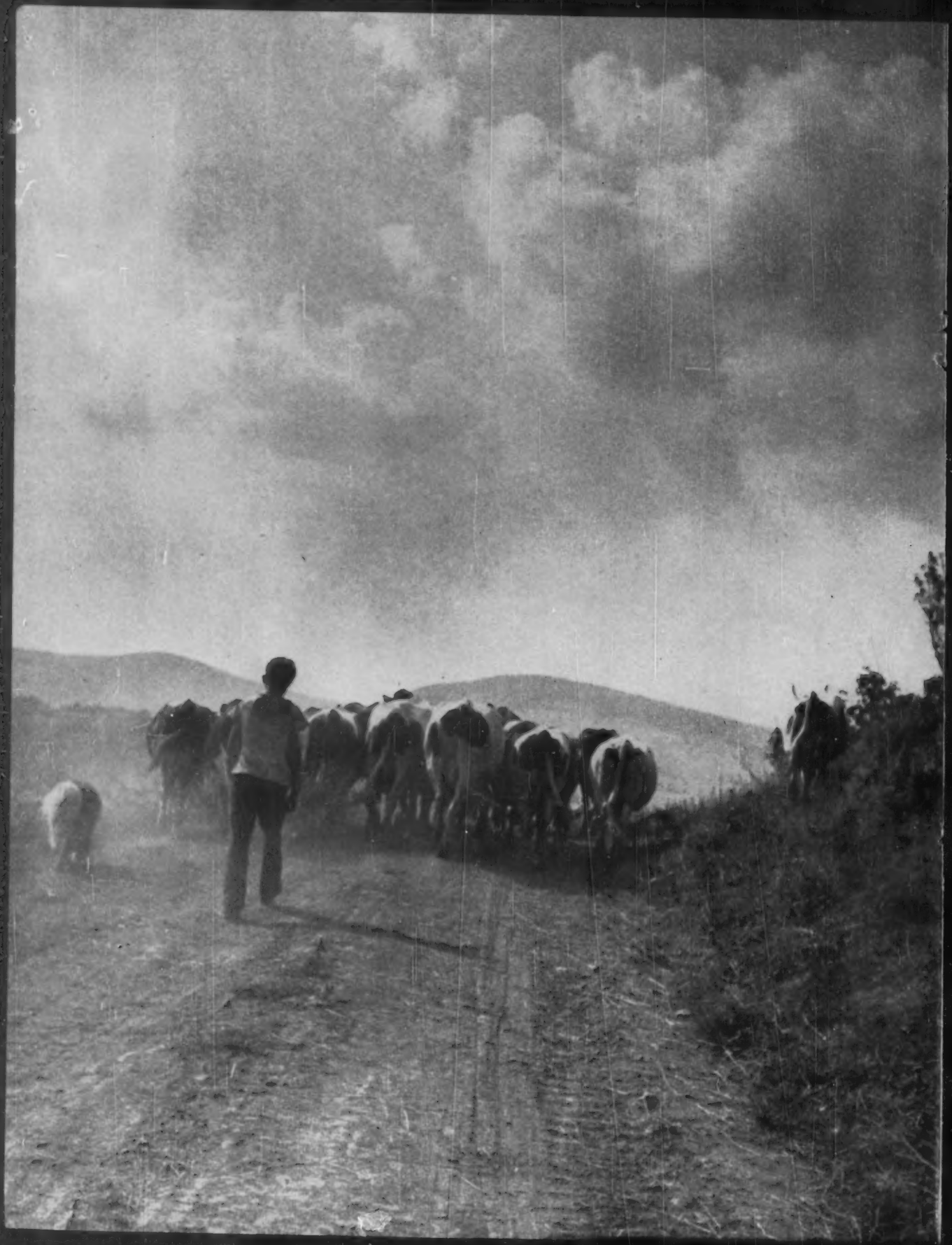
AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Problems of Rural Youth

Day Care for Deprived Children

Identifying Abused Children

Citizen's Role in Welfare



AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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HELPING OUT ON THE FARM, once a realistic vocational preparation for most rural youth. Today with opportunities for farm careers dwindling as agriculture becomes increasingly mechanized and industrialized, most rural youth must turn cityward for hope of employment. Problems of preparing young people in rural areas for life in an urban society are discussed in the article which begins this issue.

Dr. Lee Burchinal (left), as of mid-September, is acting chief of the research grants branch of the Research Division in the Office of the U.S. Commissioner of Welfare, Department of Health, Education, and Welfare. Previous to his going to the U.S. Department of Agriculture a year ago, he was professor of sociology at Iowa State University. Dr. James Cowhig, also a sociologist, was at one time with the Michigan Department of Mental Health.

In addition to her position at the natural history museum, Margaret Mead holds a professorship at Columbia University and visiting professorships at the University of Cincinnati and at the Menninger Foundation, Topeka. Her research in primitive societies has resulted in numerous publications, beginning in 1928 with the still best-seller, "Growing Up in Samoa."

A graduate of the New York School of Social Work, Eleanor Hosley has been with the Day Nursery Association of Cleveland since 1937, first as head of its social service department and since 1947 as executive director. She is also senior instructor in child development at the school of medicine at Western Reserve University.

A graduate of the Smith College School of Social Work, Elizabeth Elmer teaches in the medical school of the University of Pittsburgh in addition to directing the 50 families project she describes in her article. Before going to Pittsburgh in 1954, she did psychiatric casework with children at the Strong Memorial Hospital in Rochester, N.Y.

In addition to his professional duties, Dr. Alfred Kahn carries responsibilities as consultant to the Citizens' Committee for Children of New York City, Inc., and as chairman of the commission on social work practice of the National Association of Social Workers. His recently published book on social planning is reviewed on page 196.

Besides her work at UCLA, FLORENCE GOLDY (right) has done social work research in the Home Care Departments of the Montefiore Hospital in Pittsburgh and the City of Hope Medical Center at Durate, Calif. ALFRED KATZ (left) has his Ph. D. in social welfare and teaches at the public health and social work schools of UCLA.

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RURAL YOUTH IN AN URBAN SOCIETY

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THE 13 million young people between 15 and 19 years of age in the United States today are members of a highly urbanized society which has seen rapid and far reaching technological and social changes. They will enter a labor market characterized by rapid automation and shifts in employment from production to service jobs. Most of the available jobs will require comparatively high levels of intellectual ability, formal training, and a capacity to work with others.

One-third of these 13 million young people are now living in rural areas—on farms, elsewhere in the open country, or in villages of less than 2,500 people. How will they fare in this increasingly urbanized society?

Any realistic discussion of rural youth today must begin by recognizing that many young persons now living in rural areas will pursue their adult careers in urban communities. Even now the rural labor market has more people than jobs. Employment in farming is declining and will continue to decline. Expected increases in jobs available in rural areas will not provide adequate employment for the rural labor force in the foreseeable future. Thus many rural young persons must follow the traditional path of migration to the city in search of work. But such migration now occurs under a new condition: urban areas no longer need nor can they absorb masses of unskilled workers.

Conditions are also changing in rural areas. Successful farming today requires higher levels of technical and managerial competence than in the past. And the kinds of jobs held by rural-nonfarm residents are becoming more like those of city persons. Thus, whether rural youth seek rural or urban employment, they face similar circumstances—the need for more education or specialized training than rural youth of a generation ago, and the prospect of harder competition for jobs.

How well are rural youth prepared to meet these conditions? There is reason to believe that in comparison with urban youth, rural youth are at a distinct disadvantage.

Advances in transportation and communication and a long period of general economic prosperity in the country as a whole have reduced, but have not eliminated, rural-urban differences. Some of the differences, especially in education, seriously impede rural youth from fully realizing their employment potential. Moreover, reliance on older rural work values such as physical strength, informal training, and being one's own boss may handicap rural youth in preparing for work in a society dominated by large-scale organizations with highly specialized work roles.

Almost half (6 million) of the rural youth 15 to 19 years old in the United States in 1960 were living in the South. One million of them were Negro. This means that the problems of rural youth have a regional and a racial aspect.

To illustrate some of the problems of rural youth, we have drawn upon a wide range of research data. Some of these data supply only a limited basis for generalization, either because they were drawn only from one specific geographical area or because the treatment of certain important variables, such as

The views expressed are those of the authors and not necessarily those of the United States Department of Agriculture.

socioeconomic status, differed in the various studies from which they were derived. In spite of these limitations, we believe the consistency of the data allows some generalizations that throw light on important problems facing young people in rural areas.

Backgrounds of Rural Youth

Comparisons of the backgrounds of rural and urban youth indicate that on the whole:

• ***Parents of rural youth have lower levels of education.***

National data are not available on the educational levels of parents specifically, but years of education are reported for all persons 25 years of age or older. What is true of these adults probably is also true for the parents of rural and urban youth. In 1960, the median of years of education achieved by white urban males 25 years of age or older was 11.3, as compared with 9.4 for white rural-nonfarm males and 8.7 for white farm males. Educational levels for Negro males were considerably lower: urban, 8.5; rural-nonfarm, 5.8; and farm, 4.8 years of education. Similar differences existed among women.

• ***Rural families have lower incomes.***

In 1959, the median money income for all white urban families with two children under 18 was $6,678. Medians of income for white rural-nonfarm and white farm families of this composition were $5,549 and $3,863, respectively. In marked contrast, the medians for Negro families were: urban, $4,469; rural-nonfarm, $2,645; and farm, $1,323. Thus Negro farm families average only one-third as much income as white farm families.

Families with incomes below $2,000 are often referred to as low-income families. On this basis, low incomes are more prevalent among rural than urban families, and is especially acute among Negro farm families. Less than 2 percent of the white urban families and only 5 percent of the white rural-nonfarm families, but 20 percent of the white farm families had incomes under $2,000. Almost 10 percent of the urban Negro families had an annual income of less than $2,000, as did 36 percent of the rural-nonfarm Negro families, and nearly 70 percent of the Negro farm families.

• ***Higher status and white-collar jobs are underrepresented among rural workers.***

Differences in the industrial base of rural and urban communities are reflected in differences in occupational distributions. Most obvious, of course, are the higher proportions of rural men primarily employed in farm occupations (26 percent compared with 1 percent of urban men) and the lower proportions of rural men in white-collar jobs (22 percent compared with 40 percent of urban men). Even so, a smaller proportion of rural men were primarily employed as farm operators (18 percent) than as white-collar workers. However, many rural men primarily employed in other occupations are part-time farm operators or farm laborers and are dependent on agriculture.

Differences between the percentages of rural and urban men employed in blue-collar jobs (craftsmen, foremen, operatives, and kindred workers) or as nonfarm laborers are minor. The occupational distribution of the rural-nonfarm labor force closely resembles that of the urban labor force, but the proportion of "white-collar" workers in the rural-nonfarm category is below that of the urban labor force.

The educational and income disadvantages of rural families suggest social, cultural, and material disadvantages for rural youth. Other data support this inference. For instance, national polls of rural and urban youth indicate that rural parents and youth read less, make less use of libraries, and have fewer magazines or books at home.[1] Moreover, smaller proportions of rural than urban youth obtain preventive medical care or are covered by health insurance programs.[2]

• ***The quality of rural education still lags behind.***

While there are many excellent rural school systems, national data still point to a lag in rural education. The Department of Rural Education of the National Education Association, in comparing urban school systems with school systems that primarily serve rural children,[3] found that the teachers in rural schools have less education, receive lower salaries, are not so often members of professional educational organizations, and have more complicated teaching responsibilities—about twice as large a proportion of rural as urban teachers teach more than one grade and teach more than one subject. Furthermore, current expenses, instructional costs, and current value of school property—on the basis of per pupil in average daily attendance—are much lower in rural than in urban school systems. Rural averages are lowered considerably by figures for southern rural schools.

However, there are some indications that rural educational systems are attempting to catch up. New capital expenditures for rural districts (based on

average daily pupil attendance) have been exceeding similar expenditures that have been incurred in urban school districts.

Educational Attainments and Aspirations

What effects do differences in family and educational backgrounds have on rural youth? Data on three sets of job-related characteristics are used to shed light on this question: (1) the educational attainment and aspirations of youth; (2) their occupational perspectives; and (3) their social-psychological characteristics, including personality traits, attitudes, and values.

• ***Rural-urban differences in school enrollment are slight through high school.***

In 1960, about 75 percent of all urban youth and 73 percent of all rural youth 14 to 19 years old were enrolled in school. School enrollment among young people between the ages of 14 and 17 living in farm and in rural-nonfarm areas and in urban areas also varied only slightly. Among 18-year-olds, 53 percent of urban residents and 46 percent of rural residents were enrolled.

High school graduation has become a *rite de passage* for most youth, rural and urban alike—despite the socioeconomic differences among them. However, some studies have shown important differences in attitudes toward education. In several polls, greater proportions of rural than urban students expressed the opinion that their teachers were paid adequately or were overpaid. In contrast, greater proportions of urban than rural students said they thought their teachers were underpaid.[4] Thus urban youth seem more fully to appreciate the services rendered by their teachers.

In another poll, rural students expressed less interest than urban students in six areas of study: mathematics, foreign languages, science, English, history, and the social sciences. Only in biology did rural students show greater interest than urban students in an academic discipline. On the other hand, rural students expressed the greater interest in shopwork, vocational training, driving, and home economics—subjects directly related to vocations.[1]

Proportionately more rural than urban students said they felt their school curriculum was restrictive and that they wanted additional courses, particularly vocational training, not now offered at their schools. Rural students also more often disliked their courses and had unfavorable views toward school in general.[5] Only 36 percent of the rural students, as against 51 percent of the urban, said they thought their schools

Developing a skill with tools, as is this rural boy in a 4–H Club program, may have vocational and avocational overtones for nonfarm or city boys as well as those planning to farm.

helped them sufficiently to discover their vocational abilities.[6]

• ***Rural youth are less likely to continue education beyond high school.***

According to a number of national surveys and State and local studies, smaller proportions of rural than urban youth plan to continue their education beyond high school or actually attend college. Only about one-third of all rural high school graduates in 1959 enrolled in college in 1960 as compared with almost half the urban graduates.[7] These differences persist when rural and urban samples are equated according to the intelligence levels of youth and the status levels of their families.

• ***Lower educational aspirations are most frequent among farm youth and their parents.***

Lower levels of educational aspiration among farm-reared persons may be partly due to the lower educational and economic status of farm families, but also may reflect a lower value placed on education by farm people.[8] In a national survey, equal proportions of males 16 to 24 years old from rural and urban areas (19 percent) gave "lack of funds" as the reason for not being enrolled in school, but the reason "no desire to attend" was given more frequently by farm youth (39 percent) and least often by urban youth (29 percent), with rural-nonfarm being in between (35 percent).[9]

Even in prosperous agricultural areas of the Middle West, proportionately fewer farm boys than

rural-nonfarm or urban boys plan to go beyond high school; and the parents of rural youth, whether farm or nonfarm, are less likely than those of urban youth to encourage college attendance.[10] Among farm-reared boys, regardless of family income, those planning to farm are less likely than others to plan for education beyond high school.[11] In Michigan, farm youth apparently regard education as more important for boys planning not to farm than for those planning to farm.[12]

• ***Among college students, rural youth may be less well prepared than urban youth.***

National data are lacking for comparisons of the college preparation of rural and urban youth. However, there is some evidence that rural youth who do attend college are usually less well prepared than others. In an extensive review of research on the gifted and talented, Fliegler and Bish report agreement among the findings of several studies that underachievement among college students is related to rural backgrounds.[13] Another study found college entrance scores to be considerably lower for rural than for urban students, and that a greater proportion of freshmen from rural areas entered with academic deficiencies.[14]

Occupational Achievements

• ***Rural-reared men generally are less successful in urban job competition.***

Rural-reared men are disproportionately represented in manual and low-prestige occupations. Several studies have shown that the lower levels of education among men from rural areas were mainly responsible for their poorer occupational achievement; but in one, even when farm-reared and urban-reared men with similar levels of education were compared, farm men were disproportionately represented among those working in low-paying occupations.[15]

• ***Rural youth usually have lower occupational aspirations than urban youth.***

Comparisons of the current occupations of rural-reared men and urban-reared men now living in cities reflect the experience of the last generation of youth. However, studies of the occupational aspirations of today's high school students indicate that rural-reared males probably will continue to be overrepresented in lower status occupations. National polls as well as findings of studies in a number of States—Kentucky, Michigan, Iowa, Florida, and Washington—show that greater proportions of rural boys than urban boys expect to enter manual, semiskilled, skilled, or clerical occupations. Some of these studies found higher levels of occupational aspiration among urban than rural males even when comparing boys of similar intelligence levels or boys from families of comparable status levels.[8]

Several factors help explain these rural-urban differences in levels of occupational aspiration and achievement. For one thing, rural youth probably are less well informed about occupational alternatives than are urban youth. While systematic data are not available on the extent or competence of counseling available to rural and urban youth, there is evidence that in comparison with urban students, rural students lack access to vocational counseling services and up-to-date knowledge about occupational opportunities, their training requirements, work roles, rewards, and related characteristics. For example, a study in Georgia found rural boys to be less well informed than urban boys about sources of knowledge concerning occupations, and more likely to list informal sources of information, such as friends, instead of formal sources, such as employment services.[16]

In various ways, parents influence the educational and occupational perspectives of their children. Several studies indicate that rural parents are less likely than urban parents to encourage their children to go beyond high school. Proportionately more urban boys than farm, rural-nonfarm, or small town boys have reported that their parents discussed occupational plans with them.[8]

The occupations of fathers and the occupational structure of the community also influence the plans of youth. Farm boys who plan to farm have had intimate experience with farming. Their fathers can help them greatly in their plans. In contrast, fathers of farm boys not planning to farm often cannot provide their sons with much occupational advice. Several studies have found that farm boys planning for nonfarm jobs are less likely than other classifications of boys (urban, rural-nonfarm, or farm boys planning to farm) to have discussed their plans with their parents.[8]

Moreover, in many rural communities, particularly those dominated by farming or remote from metropolitan areas, the bulk of employment is accounted for by only a few occupations, most of which are manual, semiskilled jobs. The youth of these communities have little opportunity to become familiar with a wide variety of work roles.

All of these data point to the same conclusion:

Rural youth need considerably greater help than they are now getting in becoming acquainted with the world of work.

Farm-Reared Boys

Farm boys especially seem to be in need of vocational assistance to decide between farming and a nonfarm job. On the basis of several statewide studies, we estimate that about 40 percent of farm boys plan to farm. However, only about 10 percent of the boys now living on farms can expect to become operators of farms large enough to yield at least $2,500 net income per year.

Regardless of the economic status of the boys' families, smaller proportions of boys planning to farm than of boys planning nonfarm careers expect to continue their education beyond high school. Farm boys usually have considered fewer occupational alternatives, have made their occupational choice at earlier ages, and are more certain of their plans than the other boys.[8] Consequently, farm boys planning to farm appear to be less well informed about nonfarm job opportunities and less actively to be seeking such information.

Studies in Michigan and Iowa found that farm youth who had decided to farm sought occupational information from school sources less frequently than other rural youth and were more satisfied with their present sources and levels of occupational information.[8] Another investigation found them less well informed about the cost of becoming established in several types of nonfarm occupations and about the prestige and incomes of some nonfarm jobs.[11]

These findings may mean that many boys who plan to farm make up their minds without much consideration of job alternatives. They may drift into farming because they think it is expected of them, or because farming is the only occupation with which they are familiar. Their backgrounds, which often include enrollment in vocational agriculture in high school, provide them with little knowledge of alternative jobs.

Most boys who say they plan to farm will not be able to do so. If those who begin farming and later must shift to nonfarm jobs have not acquired a broader education, they will be at a disadvantage in job competition.

Characteristics of Rural Youth

Ideas rural youth hold about themselves, education, jobs, and changes in ways of living influence their plans and their adjustment to urban life and work. Precise and reliable measurements of attitudes and personality characteristics are difficult to achieve, but the limited data available suggest that rural youth, especially farm boys, are psychologically less well equipped than urban youth for living in a metropolitan society.

Take the ideas youth have about work. One study shows that farm boys put greater emphasis on the freedom to be their own boss, whereas nonfarm boys attach greater importance to the intellectual challenge of a job; another reports that farm boys generally prefer to work with things, whereas boys living in towns prefer working with people; and another, that farm boys are less willing than urban boys to accept changes in patterns of living or to move from their communities to take advantage of opportunities.[8]

While some past studies have shown few differences in personality characteristics among farm, rural-nonfarm, and urban youth, recent research, based on more reliable tests, suggests that rural youth are at a disadvantage in relation to qualities which make for success in the world of work. Rural youth in Minnesota expressed greater feelings of shyness, self-depreciation, and suspicion than urban youth.[17] In a Michigan study of farm, village, rural-nonfarm, and urban boys, farm boys showed the greatest indications of submissiveness, shyness, or withdrawal tendencies.[18] Urban boys scored highest on dominance, aggressiveness, self-confidence, and self-sufficiency. These findings suggest another set of differences that may impede the adjustment of rural youth to urban areas and limit their ability to compete with urban youth.

Such social-psychological data, along with data regarding educational and occupational aspirations and achievement, suggest that rural and urban environments have marked, differential influences on youth.

Helping Rural Youth

Clearly, the talents of many rural youth are far from being fully developed, with resultant losses: (1) in the Nation's productivity because of inefficient workers; (2) in the economy because of the necessity for providing for unemployed persons and their families; and (3) in personal satisfactions.

Programs to reduce these losses require modifications in many aspects of rural community life, looking toward two main goals:

1. ***The provision of opportunity for all young people to receive an education through high school, suited***

to their individual needs, and, for those with sufficient ability, to receive additional education or training.

To attain this goal requires efforts to motivate every student to achieve his educational potential, develop basic skills, and discover and develop his abilities. In many areas it will require school reorganization, upgrading of instruction, and expansion of special services, especially programs of vocational education and vocational counseling services.

While this process is already underway in some communities, in some depressed rural areas it will require massive injections of outside capital, leadership, and personnel. These are the same areas from which the most poorly equipped rural youth migrate to metropolitan centers for the purpose of obtaining employment.

Readily available vocational education programs are especially needed for rural youth. For young people who have realistic opportunities to enter farming, agricultural education is important, for farming will continue to require increasing levels of management and technical skills. However, the bulk of rural youth need training for work in nonfarm occupations.

Extensive vocational counseling, provided early in high school, is necessary to help rural youth achieve realistic views of occupational choices.

2. ***The preparation of rural youth for geographical and social mobility.***

Community leaders in continuous contact with rural parents and youth can help alter conceptions that contribute to the disadvantage of rural youth, especially by emphasizing the necessity for advanced or specialized education. Adult education programs can help rural parents to appreciate the value of education in modern society and to provide more effective educational, vocational, and social guidance for their children.

The challenge to persons interested in the lifelong welfare of rural youth is to develop rural community life in ways that will prepare rural youth for equal competition with urban youth. A broad approach, in the schools, with parents, and with rural leaders, as well as with the young people themselves, is needed to accomplish this end.

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Only by real freedom from need can we give the individual a liberty which is more than formal.

From report of the December 1962 meeting of European Economic Community Conference on Social Security.

How grandparents, parents, and children can contribute to . . .

THE CHANGING AMERICAN FAMILY

MARGARET MEAD

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IN different parts of the United States today we have examples of families which, in their structure, represent different periods in our historical development. In some rural areas and among some immigrant groups, we still have the large three-generation family which often includes other relatives; in most of the United States we have the two-generation family of husband and wife and minor children. In both types of families there has been an assumption that it was the adults within the family who, in addition to succoring and nurturing the young, were also essentially authorities on what was right or wrong, correct or incorrect, important or trivial within the culture.

The old three-generation family was particularly suited to cultures with little or no change, where young adults could be supported and guided by the experience of their elders because their own experience was essentially the same. Breaks in such slow transmission of culture came with accelerated immigration from other countries—in which case the young people learned new ways and the grandparents did not—with migration within the society from the country to the city, and with change in social class, a continuing feature of American culture. The two-generation or "nuclear" family became the most flexible and suitable form through which old traditional ways of life could be abandoned and children reared just to the age at which they were ready to go out and involve themselves in a changing world.

It is not generally recognized that we are moving toward a new family form, not yet named and not yet clear. But the conditions which underlie the emergence of this new form are clear enough.

One of these conditions is: an accelerated rate of change so that not only may adolescents and parents expect to see a changed world—a world for which they cannot be prepared in detail—but grandparents must also expect to live for many years in active relationship with a world that is constantly changing. The day of retiring grandparents to a convenient chimney corner or seat at the club to reminisce about the past is departing. For the grandparental generation is the greatest source of information about a problem facing everyone—how to stand change.

Today's grandparents have lived through the most rapid changes the world has ever known. It is not their experience of old, tried ways but instead their experience of the arduous and trying process of continuous adaptation to new ways that is now needed. Once, "I had no grandmother" meant "I know very little about the past." Now, "I have no grandmother" means: "I don't know enough about change. I am boxed in, in a present that I treat as given; I have no time perspective because I don't know enough about what it was like to change from the horse and buggy days of the past."

So the grandparent, who in a great majority of last generation American homes could contribute very little except love and nostalgia to the grandchildren, is now needed in quite new ways, not only

Condensation of an address given at the 75th Anniversary Year Conference of the Child Study Association of America, March 4, 1963.

in individual family life but also in all of those organizations which support and extend the role of the family in the education of children—child study groups, PTA's, and so forth. Everywhere there is an urgent need for the older people who have changed successfully, have kept pace with the world, who can communicate a sense that something has or could be done.

Supports Needed

The second condition demanding a new form of family is the need for greater support for young couples who have married early and are attempting to bring up children under extremely difficult conditions and for the very large number of one-parent families, faced with an even more difficult task. The breakdown of young mothers who have neither friends nor female relatives nearby has been studied as one index to the increasing precariousness of life in the unsupported nuclear family.

Whether this problem will be met through greater participation in and control over the marriage of young people still in their teens by real or substitute relatives, or how much educational institutions will exchange regulation of individual students' lives for responsibilities for their students' children are uncertain questions. Nor is the question settled of whether our extreme American individualistic style of homemaking, which has produced women incapable of sharing a kitchen with another woman, will be able to generate closer forms of cooperation. But something is definitely needed to end the isolated, exposed position of two very young parents (or one parent alone) attempting to rear several children all by themselves with no one to advise and comfort, no one to take over in emergencies, no one to rely on in regard to the small day by day details of living. This need is of course simply accentuated by the number of these women who are working full or part time and adding a second responsibility—to a job—to the first which is already too much for them.

The third condition is the extent to which parents can no longer control the moral training of their children. The capacity to make a distinction between right and wrong is universal among contemporary peoples and has been claimed to be an essential part of man's humanness. But in a changing situation, each set of parents is hard put to it to give clear moral definitions to their children. The present low standards of ethical behavior in many parts of our society reflect the breakdown of parents' ability to give their children clear ethical direction within a scene that has been changing too rapidly. Moral counsel has become either out of date or uncertain and vacillating.

When TV and radio were brought into the home the capacity of parents to give moral direction to children was much further reduced. *Increasingly, our children are being reared by the mass media.*

Today selective devices by which communities can take over what the individual parent seems no longer able to do—give ethical direction to children's lives—are urgently needed. This will mean the articulate delegation by the individual family of a moral role which it has long since lost, and the development of new ways for parents, teachers, and citizens to take responsibility for protecting *all* of the children of the community, the State, the Nation, and ultimately of the world.

A Shift in Roles

Finally, there has been a shift in the role of experience. Once it was the grandparents who were wisest, then it was the parents reared within the present age who were most able to direct their children. *Now it is the children who are most at home in the world, and the adults who are strangers.* The family needs to be reorganized so that the adults can absorb the children's growing knowledge of the present age—of space, of satellites, of the new mathematics, and of the oneness of this small planet called Earth.

Fortunately, as a nation of immigrants, we have already been somewhat accustomed to learn from our children—who were born here, spoke "American" as a mother tongue, lived here as their immigrant parents never could. We adults still have to give children a sense of right and wrong and a sense that there are some things more valuable than others. But doing this in the world of today and tomorrow will require us to have the flexibility and ingenuity to develop ways in which we can feed back into the family, and into supporting social agencies and organizations, the grandparents' experience of change, the moral responsibility of the parents, and the familiarity of the children with the brand new. This will be a new kind of family grown from conditions that have never existed on this planet before.

CULTURALLY DEPRIVED CHILDREN IN DAY-CARE PROGRAMS

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IN RECENT YEARS there has been growing awareness that large numbers of children in the poverty stricken centers of our large metropolitan areas have difficulties all through their school experience because of lack of intellectual stimulation in their earlier lives. This awareness has reawakened an interest, which ran high during World War II, in providing educational experiences along with daytime care for preschool children, an interest which lagged considerably in the postwar years. Now as the relationship of cultural deprivation to poor school adjustment—and hence frequently to social maladjustment—is becoming more widely recognized, divers groups with all sorts of backgrounds have picked up the torch and are attempting to provide an educational experience for preschool children, especially those of deprived backgrounds. Unfortunately, the eagerness to feed the minds of these children sometimes takes on the aspect of people rushing in with baskets of candy for the starving. The long, slow process of preparation necessary for successful work is overlooked in the search for magic formulas.

When children have been "culturally deprived" they have often also been deprived emotionally as well as materially. Hence the process of helping them to achieve their potential becomes a far more complicated one than merely reading to them for a few hours a day. Experiences in some of the day-care centers associated with the Day Nursery Association of Cleveland can be used to illustrate the complexity of the process.

The Day Nursery Association of Cleveland has been in existence for 80 years. Although its primary function is providing day care for the children of mothers who must earn a living outside the home, it has always engaged in related activities. For example, it started free kindergartens and the training of kindergarten teachers in Cleveland and opened one of the first nursery schools in the United States. Nursery education is regarded as an integral part of the service to all preschool children who attend the Association's centers.

At present the Association operates five day-care centers and, in cooperation with the Division of Psychiatry of Western Reserve University's School of Medicine, a therapeutic nursery school and a kindergarten for children with problems. It also provides consultation through a staff of three specialists in early childhood education to mothers in the selection of appropriate resources for their young children and to various preschool centers in the area, including nursery schools, day-care centers, and schools for such special groups as the hard of hearing, the crippled, and the retarded. Because the Association has found that the education of the young child can be successfully accomplished only by those possessing skill and knowledge, it also offers training and refresher courses for nursery school teachers.

The Association operates on the principle that although children vary greatly in background and in ability a sound nursery school philosophy in which individualization is implicit is as applicable and important for one group of children as another, though

different educational emphases may be required. Children who must spend most of their waking hours in a day-care center desperately need the enriching educational experiences that might be expected to be provided by their mother could she be with them. The child who lives in a city slum with crowds of people who have neither the time nor the knowledge to devote to his special needs also requires an enriched background, whether or not his mother has employment. So too do some of the children of the rich, especially those whose parents are constantly on the go and find paying attention to young children alien to their interests. Therefore, the process of meeting the needs of the culturally deprived preschool child from low-income areas involves the same basic essentials as the education of the 3- and 4-year-olds of more privileged background.

The material for this article is drawn principally from day-care centers that are in the heart of the city where a great many culturally and economically deprived people are congregated. One of these centers evolved from a nursery school we ran 25 years ago for yesterday's deprived children. In 1938 we tested all the children then attending, and discovered that they scored 25 points higher than the average reported for all children in the neighborhood by the local public school. Although, undoubtedly, a number of factors entered into so wide a difference, the nursery school experience was probably an important one. Since then we have added to our knowledge about how to prepare children for public school.

The children in these two centers today are there for a variety of reasons. Some have mothers so overburdened by the care of too many young children in crowded and inadequate quarters that they need help with child care in order to be able to hold their families together. More commonly the mothers are the sole providers for their families and must work or attempt to exist on substandard public assistance grants. A few of the children in the centers have been dropped from kindergarten and have been taken into the centers on the theory that a good group experience might help reinstate them.

Learning about fish in a day-care center in Cleveland—one of the many activities which help to stimulate children's interest in the world of which they are a part.

Whatever the reasons for their enrollment, many of these children come from overcrowded homes that are barren of any kind of intellectual stimulation. They are exposed to violence not only through the TV shows they watch but also in their daily living. Their vocabularies may be small but they often include a number of unprintable words. Their knowledge of the real world is confused and magical. No one listens to them seriously and no one really straightens out their thinking. If grownups hear what they say, they are as likely as not either to laugh at them or tell them to "shut up."

Work With the Parents

We have long been convinced that work with the young child must include as much work with his mother as is practically possible. While work with the father is also important, with children under 5 work with the mother is central to any progress. Therefore, the staffs of all our day-care centers include a parent counselor or caseworker. If at all possible, the mother comes to the center regularly: usually she brings and picks up her child daily. In any event, she is expected to come in for regular conferences. In some cases where the mother is sick or emotionally disturbed, the counselor goes to the home.

The centers make a great deal of the informal daily contact with the mother. All staff members are expected to be friendly and supportive, but this does not obviate realistic criticism and demands. With any mother, whether rich or poor, educated or uneducated, a board member or a public assistance recipient, a sense of being accepted as a person in her own right is the key to a working relationship. People who have been culturally deprived have experienced being pushed around, ignored, or rebuffed by the well-to-do and the educated so often that they are inclined to approach a new situation with such persons in authority with the expectation of being belittled. Teachers and counselors both have to make conscious efforts to support the self-respect of the mother as a person and as a parent.

All persons who apply to the nursery for the admission of a child are seen in the beginning by the parent counselor and later by the child's prospective teacher. The initial step in the admission process, after acceptance of the child, is for a staff member to talk with the mother about preparing her child for the new experience. Mothers are advised to make this discussion concrete, giving the child an explanation of why he is going to the center, what he can expect it to be like there, and encouraging him to express his feelings about it all. Many a mother registers surprise at such a suggestion and hotly denies the possibility that the child may find the new experience scary or that he will need her to stay beside him in the beginning. On the other hand, mothers are frequently delighted in the discovery that they can have a real conversation with their children and even more so in finding out how very important they are to them.

Sometimes it takes a long time for mothers to believe that their children miss them. For example:

When the mother of 3-year-old Susie would call for her at the center in the late afternoon, Susie would run in the opposite direction and a scene usually ensued before she went home. One day the counselor said to the mother, "What do you think Susie is thinking when you come for her?"

The mother replied that Susie was thinking how much nicer the nursery school was than home.

"She likes you best," she said sadly.

"But that's not true," the counselor responded. "All day long Susie misses you. She really wants to be with you. She has been so sad and angry because you went away that she can't show you how glad she is you're back."

This was a revelation to the mother. With a little encouragement from the counselor, she told Susie how much she missed her, and she began greeting the child with an understanding warmth that had been lacking in her earlier uncertainty.

Greeting a child warmly is a small and simple thing, but it made a difference in the relationship of this mother and child.

Neglected Children

Some children in day-care centers really do not want to go home, and with good reason. This, for example, may sometimes be true of Tommy, who was 3 years old when first brought to the nursery center by his teenage unmarried mother.

Tommy had been knocked around a good deal by his mother and by his young aunts and uncles who were part of the large family in which they lived. His mother entered him in the nursery so she could work and go to school. She did not expect him to want to go home with her after being at the center, and her fears were corroborated by his screams each day when she came to pick him up.

At the time of acceptance, the caseworker had insisted that the mother be the person to bring Tommy to the center and to stay with him on his first days there. This means of showing the mother that the nursery considered her important to her child proved to be the first step in improving the mother-child relationship. A subsequent one was an arrangement that Tommy be prepared by the teacher each day for his mother's anticipated arrival to take him home.

No caseworker has the skills to change the acting-out ways of a whole family like Tommy's. In this case, however, it has been possible to give the mother enough of a sense of value as a mother for her to begin to have pride in her child. Tommy is a bright and responsible boy, although a difficult one, and has achieved some real successes that have regularly been reported to his mother. Little by little their relationship has improved enough for them to enjoy each other. Now he is usually delighted to see her and they go off happily together. This is not always so—not long ago he screamed for three-quarters of an hour after his mother arrived. But what matters is that the movement is forward. Tommy's mother is now working toward the day when she and Tommy can move from her family and become a responsible independent unit themselves.

Sometimes the father can be drawn into playing a decisive role in broadening a child's horizons. For example:

Charlie, the youngest of a large family, showed all the signs of lack of parental attention. The counselor visited his home and talked with his mother. Couldn't she find a few minutes each day to read to Charlie? The mother brushed this suggestion aside as utter nonsense: She worked and had seven other children to attend to; how could she possibly read to Charlie? The counselor talked to the child's father, who had been unable to find a job for a long time. Couldn't he read to Charlie?

At first the father looked on the idea as absurd. He became interested enough, however, to go to the library and get some suitable books. He tried one out. Charlie was delighted and made comments. The father read some more and found himself engaged in conversations with Charlie.

It had never occurred to this father of eight children that children could be fun to talk to, and now with his last-born, he discovered they could.

This simple kind of approach is time and again surprisingly effective with people who have been uprooted and, in their struggle to survive, have lost the links with the past that might have served as guides for what to do with young children. Such basic beginnings, because they are so simple, are often overlooked by caseworkers and teachers who are searching for more complete solutions or think they can accomplish the task themselves in direct work with

the child. Whenever it is possible to remove the obstacles that stand in the way of parent-child relationships it is enormously important, and worth doing. The ancient Chinese proverb that "even the longest journey starts with one step" is worth recalling.

There are, however, some families in which the lack of parental interest is so complete or where the interest is so distorted that work with the parents by the nursery school staff is precluded. Some children come to us from homes where they are not only neglected, but mistreated, and referral to a protective agency is in order. However, if the child happens to be a Negro, unless he is in serious physical danger, there is little use in referring him to a protective agency for possible removal from his home because of the inadequacy in resources for the foster care of Negro children. If the maltreated child has not developed aggressive acting out symptoms which are dangerous to the group, he may be helped by skillful and sympathetic handling in a day-care center. The actual relief that comes from protection, order, and peaceful care for at least part of the day offers him something. The unique feature of a day-care center, as against a nursery school operated as a strictly educational enterprise, is its long hours. This has a special value for children who need protection. The educational experience they get in the day-care center may be even more important.

The Educational Program

All good schools, including nursery schools, correct and enlarge on factual material the children pick up in their daily lives. Children always come to their teachers with some distorted ideas about reality because their experience has been so brief. Nowadays uncensored viewing of TV may add to their confusion. Even children deprived of many basic necessities are apt to be exposed to television. As a result, the Three Stooges, cowboys and Indians, and the strange transformations that take place on commercials form a tangled web of distorted reality in many a child's mind. We had one little boy who thought rabbits laid carrots especially for the supermarkets. In the slum cores of our cities, where few adults take the time to respond to a child's natural curiosity about the unfolding world, the child's conceptions may be strange indeed.

The essence of nursery education is helping a child to learn essential facts about the outer world and the inner world, and how to separate fact from fantasy in order to be able to learn to manage both. Moral standards and attitudes are explicitly explained in relation to actual experiences. Involved throughout, for both staff and children, is that most important aspect of human learning: the art of communication through words. This art is for most of us harder to exercise than we commonly realize.

People sometimes fail to recognize the extent to which language can block communication. Intellectuals sometimes have great difficulty in talking to young children or uneducated adults in terms they will understand. Nursery school teachers often need a great deal of practice before they develop the skill of putting their ideas into words that will have meaning for children. And those who are good at this seem to have a special knack in talking with meagerly educated parents.

In any event language to have meaning must be based on real experience. To have color, it must include feelings. Therefore, the nursery education program includes a variety of everyday experiences of the kind that can be understood by the young. Short trips to neighborhood facilities, parks, fire stations, pet shops, or stores are frequent. The children engage in a variety of creative activities including painting, cooking, and carpentry. They listen to stories. They play with toys. They have plenty of opportunity to talk to each other and the teachers, asking questions and expressing their own ideas. In this way, the ability to use language for thinking and communication is built. From these activities they derive the mental stimulation essential for the preschool child's cognitive development.

People often confuse stimulation with excitement. They think that taking 3- and 4-year-olds to the circus or to see Santa Claus will provide a wonderful kind of entertainment. Actually some children of such tender years will be terrified by such experiences and only become more confused. In fact, one of the positive experiences a well conducted nursery school can offer a child from a teeming city slum is freedom from excitement and a predictable orderly existence.

This was true of Martha and James, two children in the nursery center on a protective basis, who profited greatly from its program.

The mother of these two young siblings had been hospitalized for mental illness but was now at home. She was relieved to have the children out of the way every day. The father was violently cruel and sometimes beat his wife and children. However, he liked the idea that the center would teach the children how to behave and would prepare them for school, and he was willing to bring them there. The most that could be done with these parents was to support their

belief that bringing the children to the center every day was worth the effort.

When they first came to the nursery, James was withdrawn but Martha had violent temper outbursts. Both children were interested in all the play material. They both enjoyed stories. Their difficulties lay in their relationship to others.

Skillful interpretation by the center's teachers gradually drew James out and helped Martha master her temper outbursts. They were told that things were different here than at home: Here nobody hit children no matter what they did; the teachers did not allow children to hurt others or to be hurt by them. This message was delivered many times in various ways. The limits on the children's behavior were firmly held, but they were given free rein to express their reactions verbally. All the while they were learning to do things and were deriving pleasure from their accomplishments. They made friends and they came to trust the teachers.

By the time these children were old enough for public school they had developed sufficiently to make a satisfactory school adjustment.

Some Handicaps

In discussing the education of culturally deprived children it is well to remember that their parents are also culturally deprived, but even so represent as great a variety of individual personality and potential as any other group of people. Many of them, however, have sunk into despair because they are cut off from the mainstream of opportunity in our society. Many had their origins in a very different kind of life than the life they are faced with in the crowded core of a great metropolis and are prepared neither by education nor background for city problems. Most of them are undoubtedly born with adequate intelligence, but too often they give the impression of slowness or even retardation because their intelligence has never been cultivated. The experience of having someone to take a real interest in them and in their children goes a long way in helping their children, at least, to a better start in life.

There are some parents, of course, who cannot profit from this interest. Some do not have the mental capacity to be good parents. Some have become so warped as to find their satisfactions in perverse or criminal acts. A few apparently do not care what happens to their children or get their satisfactions from victimizing them. Some are so disorganized that they could never get their children either to a part-time nursery school or a full-time day-care center on any regular basis. Helping these people is a far more complicated affair than helping those whose central problem is deprivation. Present day knowledge and skill are insufficient to help some of the most distressed.

We must never forget, in our enthusiasm for what nursery education can do for deprived children that there are complex, interwoven social pressures that must also be relieved if any complete solutions to the problems they present are to be found. Poor housing and the dreadful overcrowding that exists in many central cities proliferate problems that block our best educational efforts. Racial discrimination in its many forms has an even more deleterious effect. One has only to listen to children's tragic expressions on how they feel about belonging to a discriminated against minority group to know the bitterness it engenders. For example, a 5-year-old Negro boy told his nursery school teacher he'd rather be a rhinoceros than have dark skin. He said it was no use for him to be smart—he was going to be stupid and not learn anything. Being very bright, he illustrated how this could be accomplished by saying that 3 and 6 made 7.

Blows to self-esteem may interfere with the ability to learn. The inadequacy of public assistance grants and making scapegoats of people who receive them, including their children, also does severe damage to some young children of a kind that is not easily repaired.

In spite of these handicaps to its efforts, a good nursery school, which includes parent counseling, can usually promote a child's ability to learn. The importance of helping children and their parents to exchange their thoughts and feelings in words cannot be underestimated. This can be a central factor in improving family relationships and in fostering a child's capacity for later learning. Moreover, the variety of everyday experiences available in a good nursery school forms a basis for wider learning and expression.

Our inner cities and some blighted rural areas are sources of infection for our entire society. They are danger spots if nothing is done to help the children who live in them. They provide a challenge to educators and social workers, and for the country as a whole an opportunity for proving the real potentials of a free society.

A followup study of children with multiple bone injury provides clues to . . .

IDENTIFICATION OF ABUSED CHILDREN

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THE AMOUNT of systematic research on the problem of child abuse and neglect is conspicuously scant. Abundant material is available about individual mistreated children and particular abusive families but data are lacking on comparable groups of children or families selected for study according to carefully defined criteria. This means that few objective guidelines for child protection have been firmly established; for example, little is known about the long-term effects of abuse on the child or about the nature of the factors which determine the outcome of rehabilitative efforts with the families.

Perhaps the chief reason for this state of affairs is the taboo in contemporary society regarding abuse and gross neglect.[1] The acute discomfort aroused by the topic leads to extremes of emotion and unquestionably accounts in part for the disregard of the subject by research workers. But practical difficulties also stand in the way of rigorous study. One imposing obstacle is the need to decide whether an abusive action has in fact occurred.

Few clinical symptoms can be directly correlated with the mistreatment of children. Abusive acts perpetrated by the children's own parents or substitute parents usually take place within the home where the sole witnesses are members of the immediate family. Aware of society's standards, the abusers do not readily admit to abusive practices. If the child is too young to speak, there is no complainant; if the child is old enough to speak for himself, his listeners may come to conclusions based on subjective feelings instead of seeking the facts in the situation. The credibility of the child's story is also affected by the child's immaturity. Thus the principal basis for identifying the problem has had to be the judgment of the professional person. Judgment is an essential factor but it cannot substitute for objective criteria.

To help in the establishment of such criteria the Children's Hospital of Pittsburgh is carrying out a study of 50 former patients whose diagnoses included multiple bone injuries. A distinguishing feature of this condition is variation in stages of healing of several bone lesions, as shown on X-ray film. For example, a fresh fracture may be observed in one bone, signs of a healing fracture in a second bone, and signs of an old healed injury in still another. The variations in healing stages mean that the bone injuries had to be incurred at different times. This diagnosis has been chosen as the indicator of abuse or neglect in our study for two reasons: (1) multiple bone injuries in infants and young children have been documented in the medical literature as related to an environment dangerous for the child; and (2) experience in Children's Hospital has repeatedly illustrated the same connection.

In our study, abuse is defined as physical assault by an adult against a child; neglect is defined as the

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chronic failure of the adult to protect the child from obvious physical danger. For the sake of simplicity in this paper, the term abuse will be used to cover either situation.

Recognition of the Problem

The development of pediatric X-ray diagnosis extended the possibility of medical identification of abused children. However, the tardy recognition of the problem in medical circles reflects society's discomfort in facing it. In 1946 Caffey reported his observation that subdural hematoma in infants was frequently accompanied by injuries to the long bones.[2] Implicit in this report was the possibility of inflicted trauma as the cause of the patients' injuries. However, the implications of the observation were not picked up by another writer until 1953 when Silverman described multiple bone injuries as " the most common bone 'disease' of infancy."[3] In various quarters efforts were made to pin the entity to organic disease, but these hypotheses gradually proved erroneous. Many reports published during the past 5 years have added to the weight of evidence that infants and young children may be brutalized or killed through the negligence or assault of their caretakers.[4-7]

Experience shows that new fractures are not incurred when the patient is separated from his usual surroundings; that is, when he is hospitalized.[7] In Los Angeles, it has been possible to trace the course of certain patients who returned home after being discharged from the hospital.[8] This has made painfully clear the vulnerability of these children to further traumatization when the environment is not constructively altered. Knowledgeable professional persons now believe that a child with multiple bone injuries has a 50-percent chance of being re-injured should he return to his usual habitat following hospitalization.

X-rays as a Starting Point

Multiple bone injuries have been well substantiated as an indicator of abusive treatment, but certain problems exist in the utilization of the indicator. Identification of the bone condition depends on X-ray film. Although this is an objective tool, it is an imperfect tool when used to define social problems. For example, bone changes, unless gross, do not appear on the film immediately after injury. Reparative changes first appear only 12 to 14 days after injury.[7] Thus, dependence on X-ray evidence as the chief criterion of abuse may result in noninclusion of some children whose environments are dangerous. In this respect, the use of the clinical entity as indicator of abuse has the effect of limiting the size of any study group.

Another shortcoming of X-ray film in identifying abuse arises from the fact that film depicts only the condition of the bones; it cannot testify to other factors crucial to the study of child abuse. For example, the film does not contribute knowledge about the train of events leading to the child's injuries. Such information would throw light on the kind of daily care afforded the child, a factor intimately connected with the frequency and type of injuries to which the child is vulnerable.

Furthermore, important as it is as a clue to possible abuse, X-ray examination cannot identify the person who was responsible for the child at the times his injuries occurred. This may have been a sibling not much older than the patient. While the injury of a child by his sibling does not absolve the adult caretaker from his accountability, failure to prevent an injury caused by an immature sibling implies a different problem in child protection from that presented by adult assault against a child.

Finally, the film cannot define the motivation of the person responsible for the injuries. The intention which leads to an injury may have been laudable: for example, a parent may have grabbed at an infant who was about to roll off the bed. The parent's abrupt action may have resulted in a twisting injury typically found in abused children, but the obvious motivation of the parent was to protect the child. Although one occurrence of this kind is understandable, a series of injuries from such actions is unlikely to occur. Hospital experience shows that protective zeal is rarely a cause of multiple bone injuries.

All these limitations suggest that the radiologic report of multiple bone injuries is a firm starting point for exploration of social factors. Only when other data are added can the identification of abuse be validated. In undertaking research into the social factors associated with abuse, the merits of regarding multiple bone injuries as the first clue to possible mistreatment are:

1. The X-ray film provides a permanent record of the child's injuries. Such a record is less likely to be available when the diagnosis of the child's condition does not require X-ray examination. The diagnosis of simple malnutrition, for example, is not based on X-ray survey. After the signs of malnourishment disappear in response to adequate intake, there is

no objective record of the child's presenting condition, unless photographs were obtained.

2. The varied healing stages of bone lesions is irrefutable evidence that repeated injuries were incurred at different times.

While one injury may reasonably be attributed to a natural accident, it is less plausible to attribute a series of injuries to a series of accidents, especially in a very young child. Since the majority of children found to have evidence of multiple fractures are still infants, their injuries could not have resulted from unsure attempts to walk nor from climbing onto hazardous spots. An environmental factor has to be hypothesized.

3. The clinical nature of the bone findings releases professional persons from undue dependence on hearsay about the care of the child. Since children are frequently used as pawns in adults' quarrels, persons who work with children must contend with all manner of charges and innuendo against parents, often made by disgruntled relatives or neighbors who are retaliating for some grievance.

Few ways have been found to determine the real meaning of many conditions seen in children which may or may not be symptoms of abuse. However, multiple bone injuries, especially in a very young child, are now clinically recognized as a flagrant sign of danger in the child's environment. Without a glimpse of the family or a word of history, the clinician who is confronted with them knows that family factors are of primary importance for the understanding of the child and his injuries.

The Study

The present study grew out of several concerns about patients with such injuries: (1) The patient's physical symptoms often eclipse the acute social problems underlying his injuries, leading the hospital staff to concentrate on the physical injures at the expense of attention to his environment. (2) Hospital administrative policies in respect to these children and their families do not insure optimum management of the problem. (3) When abuse is suspected, few criteria exist for evaluating the family's adequacy for child care. (4) Community resources for abused children and their parents are frequently inadequate.

Our followup study of bone-injured children is designed to learn the present status of the former patients in respect to physical health, intellectual achievement, and social adjustment. Its second aim is to ascertain the kinds of families in which gross neglect or abuse occurs. It is planned as a preliminary to a second study to be concerned with newly admitted patients and their families. In this second study, the operational definitions of abuse will be expanded and comparison groups will be employed. At the present time, the knowledge necessary for choosing appropriate comparison groups is not available.

The identification of the current study group was made by two of the codirectors of the project, a radiologist and a pediatrician, who reviewed the available X-ray films of all patients ever admitted to Children's Hospital. Other children were added to the study group as they were admitted and diagnosed. The criteria for selection were:

1. Multiple bone injuries as shown on X-ray film.
2. Absence of bone disease which might account for the injuries.
3. A history of neglect or assault, or the absence of a history which satisfactorily accounts for the injuries.

Fifty such patients were found.

Among the categories of patients rejected for the study were those whose injuries could be attributed to difficult births. There are no radiologic differences between bone injuries incurred during delivery and those resulting from trauma during infancy and later childhood. This is a clinical judgment based on the age of the patient, his birth history, and his course after discharge from the hospital.[9]

Also excluded were patients who were hospitalized more than once, each time for a different single fracture. For example, one infant had two admissions, the first at the age of 5 months because of a fractured leg, the other at 14 months because of an injured humerus. Staff opinion held that the indifference of his 17-year-old mother could have led to his injuries. However, this patient was excluded from the study group.

Patients with multiple fractures incurred in a single accident were also excluded, even though the accident might have stemmed from failure to provide adequate care for the child.

Strict adherence to the criteria insures that the study group is homogenous in an attribute of consequence: All the children had had repeated injuries, signs of which were discovered during a single hospitalization.

Half the patients were male; half female. Data showing the ordinal position of the patient in their families are so meager that no groupings are possible.

The age of the patients is by far the most striking item of information: the largest group, 17, was under 3 months of age when multiple bone injuries were found; the next largest group, 9, was from 3 to 6 months old. Groups decrease in size as age increases. This is in contrast to the curve for incidence of childhood accidents which shows that the incidence rate for accidents in children is minimal below the age of 9 months.[10] It then begins a sharp climb, reaching a peak between 2 and 3 years, when it begins to level off. This contrast would also seem to support the entity of multiple fractures as an indicator of abuse.

Detailed medical information about the condition of these children on admission has been reported elsewhere.[9] What has happened to them since is indicated by some of the followup data.

Followup Findings

The incidence of death among these children is high. Three infants died in the hospital. Each had multiple fractures of the skull in addition to other skeletal injuries. Four other children died following discharge from the hospital. Two of these four children were slain by their mothers. The third was brought dead to the hospital, and the cause of death was officially stated by the coroner's office as malnutrition. The fourth child, age 5 months, was returned from the hospital to her parents after the court denied a petition to place the child in a temporary foster home. Two weeks following hospitalization, the child died of causes unknown. Thus 14 percent of the 50 children are known to be deceased. Other deaths may have occurred without the fact becoming known to the hospital.

At least three other children sustained additional injury after discharge from the hospital. One had been sent home pending the completion of arrangements for temporary foster care. Within a month she was re-admitted to the hospital because of new injuries, including a fractured jaw. The second child later suffered enucleation of an eye which was injured in the course of a beating by her mother. The circumstances of the injury to the third child are not known.

Of the remaining 40 children, 8 have not returned to any department of the hospital since the discovery of multiple bone injuries, and we have no information about them. Of the 32 who have returned, either to the outpatient or inpatient departments, 19, on examination, showed no serious physical or intellectual problem. The information about the other 13 is far from reassuring. Two were hospitalized again for prolonged treatment of chronic subdural hematomas associated with the bone injuries. Seven others had serious physical defects on their return to the hospital; four others were seriously retarded mentally.

50 CHILDREN WITH MULTIPLE BONE INJURIES

History Since Admission
Children's Hospital of Pittsburgh

Current information	Number of children
Deceased in hospital	3
Deceased after hospitalization	4
Injured again after hospitalization	3
Physical defect	7
Petition filed for institutional care	3
Retarded mental development diagnosed in hospital	1
Rehospitalized for further treatment of condition associated with original injuries	2
No information of serious difficulties	27
Have returned to outpatient department	19
Have not returned to outpatient department	8
Total	50

This table of the history of children since the discovery of their multiple bone injuries through X-rays contains documented hospital data only, and is judged to be a minimum report of subsequent difficulties suffered by the children.

Four of the seven children with serious physical defects were permanently crippled as a result of the old bone injuries; the conditions of the other three could not be clearly connected with their traumatic injuries. According to hospital records petitions for admission to State institutions for the mentally retarded were filed for three of the four children known to be mentally retarded. Each of the three was very retarded in development when the multiple bone injuries were discovered at the hospital at their respective ages of 5 months, 8 months, and 12 months. It is impossible to tell whether retardation preceded or followed the traumatic injuries. The other child regarded as mentally retarded had not yet been considered for institutionalization since she was still only 2 years old.

The foregoing account of these children is summarized in the table at the top of this page. Of the 42 patients on whom information is available, over

half are deceased, handicapped, institutionalized, or have required rehospitalization.

The Families

Hospital data about the families of these 50 patients are sparse. Until recently, social factors were infrequently explored in respect to children with multiple bone injuries. This was especially true of patients admitted to the hospital 8 to 10 years ago, before the significance of the clinical findings was widely recognized. As the conviction grew that another person had caused the injuries of the child, the medical staff began to focus efforts on obtaining a history of the trauma. However, the relationships in the child's family were not yet recognized as a critical area for inquiry. The number of consultations requested by the medical staff from the social work or psychiatric staffs of the hospital is a rough measure of the importance placed by the medical staff on family factors in the child's condition. Our study shows requests for such consultations were infrequent: they occured for 22 of the 50 children, and most of them were made since 1957.

Several pilot studies have added to the information about some of the children's families who have extensive social agency records, but this subgroup is not considered representative of the group as a whole. One of the tasks of the present study will be to spell out the details of family structure and to learn whether abusive families show any significant configurations.

Our approach to the families is to explain the study as a study of former patients aimed at improving hospital services. Family relationships are being inspected through two structured interviews with the mother, one in the home and one in the hospital at the time of the child's examinations. Data about the children are being obtained from school reports, parents' reports, and appropriate outpatient examinations.

The passage of time since the injuries makes it difficult or impossible to learn much about the circumstances under which they occurred. Whether these families were abusive or neglectful is an unanswered question; but their pathogenic influence on their offspring appears clear in the data available about the children.

Multiple bone injuries will not be found, fortunately in the great majority of abused children. The entity reflects an extreme form of deviant child care. Its mere existence, however, implies a problem of some magnitude. For every child hospitalized with skeletal injuries, there are probably many more whose injuries heal without hospital care. Still others may be subjected to the same kinds of physical mistreatment but may escape injury. This study of bone-injured children and their families is expected to lead to new understanding about children whose abuse takes milder forms, and about families whose child-care practices are deviant, but not to such an extreme.

For a report of suggested State legislation to protect children from abuse see page 202.

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THE CITIZEN'S ROLE IN SOCIAL WELFARE POLICY

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TODAY when it has become relatively easy for the technically trained professional to exclude citizens-at-large from broad areas of social welfare program and policy, it has also become urgent that the degree of citizen involvement expand. True expertise, specialized jargon, bureaucratic organization, and practice rituals all conspire to restrict communication between the professional social worker and the layman as well as citizen participation in programs. Yet the urgency of making deliberate value choices, democratically, in shaping social welfare policy demands that these obstacles be overcome.

The case for citizen participation is usually made from the perspective of the need to interpret programs to the public and to achieve financial support for necessary expansion of resources. These are valid and familiar concerns. But citizen participation which is limited to funding and interpretation does not produce adequately informed citizens who have a basis for choice in setting priorities, for achieving balance among program components, and for carrying out interpretation which goes beyond stereotypes. Thus, even these more traditional citizen roles in the welfare field require a base of policy and planning activity.

One arrives at this view whether one begins with the generally recognized need to improve the effectiveness of existing child welfare services or chooses instead to concentrate initially on the demands of a changing social scene. However, let us begin with a brief summary of those characteristics of the social scene and those service problems which demand attention and then note why the citizen's role is indeed indispensible in any strategy for improvement.

The Social Scene

It is not necessary to repeat the familiar statistics which dramatize the phenomena of accelerated social change and their ramifications in family life. Out of world political crises, automation, new forms of mass communication, and widespread social revolution has come accelerated social change at a rate never before experienced. There follows a trail of unanticipated—or at least uncontrolled—consequences: divorce and desertion; out-of-wedlock childbirth; decline in traditonal moralities; community disorganization; personal disturbance; antisocial behavior. Today we face a major problem of communication not merely between generations but between half-generations.

A major intervening factor seems to be the decline of traditional familial and primary group controls and supports. The consequence is an expanding and ever more complex social welfare, therapeutic, rehabilitative network.

All of this occurs under especially perplexing circumstances. For, while voluntary and public intervention and supports necessarily increase in response to social change and desperate need, a significant component of our national ethic continues to be based on ideology and myth which are inconsistent with a call for new or expanded expenditures and services. Through speeches, articles, editorials, and social conversation, views are often expressed which bring social welfare programs and services into funda-

mental question. Some of these views are that:

- Any well-motivated, employable person can manage to work and support his family adequately at any time and place.
- To arrive at age 65 lacking retirement funds or money for adequate medical care is a sign of personal moral inadequacy.
- Most social welfare needs can be supported on a voluntary basis (or, if public, on a local basis).
- The need for a balanced budget, in the short run, should take precedence over the need for public services, for "the government should balance its budget annually as does any individual."
- Delinquency or mental illness is always a matter of willful deviance, to be treated as such.

There can be no adequate program administration whether on a local, a State, or a national level—nor can there be reasonable planning or priority setting—unless these and related assumptions are reviewed and debated in many forums. It is necessary to decide just what is myth and obsolescent ethic and what is based on current realities. Core societal values need to be affirmed and defended as goals are chosen, while dysfunctional distortions need to be dropped. Social welfare programs, in short, grow out of implicit and explicit policies. A democracy chooses a never-ending dialogue in which differences are honestly faced and choices made. Citizens should not leave this task to professionals alone.

Continuous discussion on many levels of trends, goals, and values might also place at some new point the balance between *child welfare as service* and *child welfare as policy* (or better still, policy for families and children). For sound reasons, child welfare has been a supportive, rehabilitative, therapeutic, direct service discipline which has sought increasingly to concern itself with what public health people call secondary prevention—early case finding and intervention.

One wonders if this continues to be adequate in the face of such phenomena as the early age at which young people are marrying today and the evidence of instability in many of their marriages; the physical mobility of people caused by industrial practices, with the resultant separation of individuals and young families from primary group supports and a consequent high rate of individual and family breakdown; the new patterns for entry and return of women into the labor market and the lack of wholesome substitute care during the day for the children of many working mothers; changing sexual mores and the resultant one-of-wedlock birth rate among teenagers; the migration of underprivileged, rurally reared groups to the deteriorated inner cores of cities in the search of self-improvement, with a resulting high rate of social disorganization among them.

To respond to these trends only in terms of therapeutic-rehabilitative services—much as these do need support and expansion—is to demand an impossibly large increase in such services, to ignore social realities which create predictable problems and needs, and to miss preventive possibilities. It is also to define people in need of service as though the problems resided only in personality, character, or individual adjustment and not at all in social status.

Institutional Provision

While continuing to strengthen case services, had we not better become more inventive about institutional measures to prevent social breakdown and support sound development? Without advocating or endorsing any specific measure, one might suggest *possibilities* (of which there are many) by way of illustration:

- Programs for more adequate family life preparation at the high school level.
- Efforts to strengthen family life through a variety of social supports and educational efforts related to the period immediately before marriage and through the early years of the first child.
- Social insurance for a child against the hazard of losing a parent in the early years or of being born out of wedlock.
- Community socializing devices to support teenage development and assure a measure of control in the many situations in which the "cut off" of family control is in the preadolescent years or early adolescence, and the vacuum is not filled until adult responsibility impinges: for example, more camping opportunities for teenagers.
- Substitute homemakers, home helps, emergency baby sitters, and the like, on a scale never considered in this country, dedicated to supporting the family unit at points where it is now broken all too easily for lack of needed buttressing.
- Social supports for new primary groupings in public housing, schools, block organizations, neighborhood mobilizations, and the like, so that people with common interests may shape neighborhood norms and goals and establish the social stability which once came from the extended family.

This listing is presented only to emphasize the policy role and potentiality of voluntary and public child welfare agencies. In effect, a community (or a State, and, in some instances, a nation) at any moment makes two interesting types of decisions related to social welfare: (1) a decision as to which problems or needs are to be handled on an individualized case basis and which through more generalized social provision (and which case services are obtained by the individual after diagnostic evaluation and which as objectively achieved insurance type rights); (2) a decision as to the location of the "floor" beneath

which family and child life will not be permitted to sink. This "floor" determines when protective services come into play, how public assistance budgets are set, when courts adjudicate delinquency and neglect, and so on.

The expanding social welfare component in modern American life means that these are crucial decisions of great significance to each locality and to the Nation as a whole. Should they not be made more consciously? Should not the implicit premises be smoked out periodically and deliberate decisions made? Here, in short, is a basic charge for social welfare policy and planning personnel and for agency administrators. Even more important, here is a creative, vital, indispensable role for citizens on the boards of public and voluntary agencies, and special commissions and committees—a role which, in the last instance, they cannot delegate.

The decision as to pace, extent, balance, and boundaries between institutional and individual case approaches to social problems (or between provision for developmental opportunities and therapy) truly reflects a complex interplay of knowledge, values, staffing, power. The citizen's rightful role in this determination should be recognized and restored, even though professional knowledge and bureaucratization create forces on the side of ignoring the citizen.

To clarify just how to formulate and protect the citizen's role in social welfare is not simple. However, it is clear that legislators and officials on all levels of government need to be encouraged to carry on a policy dialogue and to determine the wishes of their constituencies. Where there is a policy vacuum, previous practice will continue unchanged or the technician will take over. Where there is no true dialogue, a few loud-voiced spokesmen, whatever their persuasions, tend to speak for all.

Equally as important as what occurs in legislative halls and in the executive offices of government is that agency boards, committees, and commissions on all levels, public and voluntary, relate themselves to policy as well as to budgets, to intake criteria as well as to program interpretation, to adjudication criteria as well as to personnel practices, to program direction and priorities as well as to quality of service. Therefore, professional staff members must find ways to explicate the implicit premises in their criteria and practices in order to introduce them to their boards as legitimate matters for policy decision and to open up other possibilities and alternatives.

Policy determination with an eye to the future, based as it is both on technical knowledge and on value choices and projections, means planning. To define, provide for, and support the citizen-at-large role in the sense here suggested is to expand family and child welfare from policy to planning. And planning is essential unless we wish to continue to refine skills without any assurance of making an increased impact on the key phenomena and problems of our times.

Service Planning

A planning process, technically staffed but involving citizens in the policy determinations, might also begin with—or would certainly soon turn to—the key problems of agencies' responsibility and accountability. The technician left to himself is always in danger of becoming preoccupied with process, ritual, and operations and forgetting the task to be accomplished, the goals to be achieved. All professionals do not behave this way, of course, but they all need constantly to protect themselves against the temptation to do so as well as against the normal pressures stemming from specialization and segmentation to assume responsibility for only part of a process. The field of social welfare, by definition, is assigned community tasks and therefore needs always to be goal-oriented. Professional goals and ethics aside, there is disturbingly abundant documentation of the degree to which:

- **Cases are found, but opportunities for service are lost.**
- **Services for an individual client are chosen through an often irrational and haphazard system of shopping around, worker competition for available resources, and chance.**
- **Children and families are "lost" in the gaps in services at points at which no one is technically "responsible."**
- **Major defects impair the continuity of care and continuity of concern for the individual case, in relation both to *concurrent* services in several agencies and *sequential* work from one agency or bureau to another.**

Family and child welfare programs have been affected by the new concern everywhere in the social welfare field, especially in mental health organizations, for case integration and program coordination. Along with this concern has come recognition that case integration and continuity of service require administrative devices for assignment and assurance of accountability for the specific case.

Where is case integration and program coordination to originate? Are administrators and board members to add this to their current concerns? Much will of course be accomplished where persons who are associated with a given operation pursue the internal logic of agency adminstration and direct-

service activity and come to understand the urgency of continuity and integration within the parts of their own operation. Even more will result as staff and board see their agency as part of a community-supported, task-oriented system of services, accountable for results and effective only as each component recognizes that it is a link in a network striving to deal with complex phenomena.

In addition, however, localities and State and national governments need to design a strategy for looking periodically beyond individual agency functions, assigned tasks, traditional services, and even new services, taking as their point of departure a social problem which has become a public concern: for example, the disorganization of family life with special reference to its impact on children. Such a raising of sights may yield new leads for services, programs, and professional training as it contributes to policy formulation and planning.

Citizens who come to social welfare policy, planning, and coordination either from the perspective of a service agency or from alertness to social change meet and interact in welfare planning councils, State commissions on children and youth, governmentally appointed advisory boards and commissions, and specialized "watchdog" agencies in specific functional fields. The experience of the past decade suggests the need to adapt the structure, staffing, and prospectives of such groups to a changing scene in which there is attention in the public sector to:

- **Program coordination in the executive arm of government, involving department heads brought together by a chairman powerful enough to give leadership and to assure implementation.**
- **A citizen policy forum in which representative and informed laymen give expression to the values, priorities, goals, and concerns which should guide coordination and planning.**
- **A technically qualified research and planning staff serving these two functional units and carrying out planning activities in the executive branch.**

While the exact format for these units must vary with State and locality, as must the structure for voluntary plannings and its correlation with the public, each of the possible patterns presupposes some guarantee that citizen concerns and values become decisive factors in policy and planning. For, while social welfare programs will continue to reflect professional knowledge and expertise, they must ultimately be instruments of community policy and objectives.

In focusing on the citizen's role in planning and policy, I do not mean to belittle the traditional and valuable contributions of the direct-service volunteer. Such volunteers, with their intimate personal acquaintance with programs, also have an especially useful contribution to make to definition of needs and evaluation of social provisions, especially at the local level. But all citizen participants in policy and planning need not and should not have concurrent direct-service connections with the agencies and fields in which they serve. Indeed, the direct-service volunteer in a planning role is at times limited by the program identification and special relationships to administrative staff which inevitably evolve through the service experience. Thus while all laymen on boards, committees, and other planning bodies need to find ways to *know* and to *understand* the meaning of services, their particular relationships to a given service or program should be defined in a way that will give them the perspective to support the role they are playing.

Both direct-service volunteer and board-level participant in policy and planning represent, at any given moment, a *community presence* in relation to a social welfare service. Such a presence dramatizes the public's interest and concern and symbolizes its full participation in a network of service and institutional provision. In a modern democratic society client, staff, and board may become the same people at different times and in different relationships. The offering and taking of service becomes increasingly the extension and acceptance of a right. The development of new social provisions reflects community decisions in which all segments of society begin to have part. The issue then is not whether the citizen should have a policy role in social welfare but rather how the role may best be supported and implemented.

A discussion of Dr. Kahn's recently published book, "Planning Community Services for Children in Trouble," appears on page 196.

SOCIAL ADAPTATION IN HEMOPHILIA

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FOR THE PAST 2 years the Medical Center and the School of Public Health, University of California at Los Angeles, have been studying the social and vocational adaptation of the hemophilic adult, a study which has many implications for the care of hemophilic children. The project, supported by a Federal grant from the Vocational Rehabilitation Administration, has been conducted in two parts. Under the first part a questionnaire survey was carried out on 1,100 hemophiliacs aged 16 and over. The 100 questions had to do with their vocational, educational, and social experiences.

The second part of the study has involved detailed investigative interviews with 40 hemophiliacs who were selected as representing relatively good or poor social adjustments. The focus of this phase, to be reported on here, was to learn more about the relationship between early childhood experiences and broad social adjustments in later life. The authors recognize that such recollections are of limited value, since adults recall their earlier life selectively. Nevertheless, these memories seemed worth exploring as having significance for parents and professional persons concerned with children with chronic illness.

Genetic and Medical Aspects

Hemophilia is an inherited disorder of the blood in which a vital clotting factor is lacking. It is transmitted through the mother to male children and usually makes itself apparent shortly after birth. About 60 percent of the known cases have a family history of "bleeders," but the other 40 percent are "new" cases which have arisen presumably from genetic mutation or perhaps from hidden inheritance through generations of female carriers. At present, there is no way of detecting female carriers by laboratory tests, or of identifying potential mutation subjects.[1]

Contrary to our expectations, the family experiences of known hereditary hemophiliacs were not significantly different from the experiences of the "mutants." The mothers in both groups were generally more protective and attentive than the child felt necessary. Mothers who felt guilty because they knew they were carriers showed no significant difference in their mother-child relationships than mothers who had not known they were carriers. Nor were mothers who had known a hemophilic father or uncle significantly different in this respect from mothers who had never known anyone with hemophilia before its diagnosis in their son.

Most of our subjects could vividly recall the change in medical management that occurred with advances in blood-banking techniques. Up to 15 years ago, hemorrhages resulting in painful swelling, unless extremely severe, were seldom treated by doctors. During bleeding episodes the young hemophiliac usually stayed in bed, with home remedies for pain being administered by parents. If the bleeding was massive and pain became unbearable, the child was hospitalized. The incidence of death from continued bleeding was high. Parents and children lived in constant fear.

Today medical treatment can often shorten bleeding episodes, prevent some residual damage, and lessen the crippling effects of hemorrhages. While the possibility of death from bleeding has not been

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altogether eliminated for hemophiliacs, the new treatments have greatly increased their life expectancy and chances for productive living. Nevertheless, the hemophilic child typically has recurrent and unpredictable episodes of bleeding that halt the usual routine of life. He is constantly exposed to doctors, clinics, and hospitals. To date, there is neither cure nor the possibility of prevention.

The Study's Subjects

Hemophilia was diagnosed at birth (or within the early months of life) in about three-quarters of the study's subjects. Early symptoms of external bleeding had usually been noted at circumcision, but as the child developed, internal rather than external bleeding was usually his major problem. While just sitting up could cause tender hematomas, spontaneous bleeding beneath the skin or from internal organs was the most disruptive problem in early childhood. Internal bleeding was experienced as more limiting, painful, and disabling than bleeding from external wounds. If, in the recollection of our subjects, the bleeding involved a knee or ankle joint, countless periods of extended bed rest, transfusions, and other medical treatments were required. Bleeding which affected joints in the upper extremities, such as elbow, shoulder, or wrist, were easier to live with in childhood, they reported, since this did not require them to stay in bed and so be separated from the family and its routine.

Because hemophilia is little understood by the general public, it is often feared that hemophiliacs will bleed to death if externally injured. Hemophiliacs themselves, however, are more concerned about the "spontaneous" internal hemorrhages of unknown origin. Sustained problems from internal bleeding such as permanent loss of sight from a hemmorrhage into the eye, or permanent kidney damage, were found in members of our study group, but most common were orthopedic disabilities, such as a rigid ankle or knee joint resulting from recurrent internal bleeding.

Despite these problems, many hemophiliacs learned early in life to conceal the fact of their illness as they became aware of people's fears about how gingerly they would have to be handled. Concealment was practiced in childhood to gain acceptance from peers; in adulthood, to avoid rejection from potential employers and social acquaintances. Our subjects drew parallels between the consequences of their misunderstood and limiting physical disorder and of such disorders as epilepsy, deafness, or cardiac disease. Thus, the problems of the hemophilic child do not seem to differ greatly from the problems faced by others who are chronically ill but normal in appearance.

Parental Supervision

The patterns of parental attitude reported by our subjects could be placed in three broad categories: (1) overprotective; (2) realistic or permissive; and (3) indifferent. They saw the roles of mothers and fathers very differently. Mothers were usually expected to be overprotective and to set limits on their young sons' activities because of their fear of physical danger. The fact that mothers had caused them psychological trauma by saying "no" was more easily accepted—"she wasn't a boy ever and couldn't be expected to know how important this game was to me"; but fathers who repeatedly denied physical activity were described with great resentment. They were regarded as traitors to their sex and as having denied the masculinity of their young sons.

When parents had differed, mother saying "no" and father "yes," the boy had felt he was masculine like his dad; but when both parents were overprotective, the boy's urge to maleness or independence had been throttled. The fact of parental disagreement seems to have been less important to the child than the emotional support he felt when his father risked the unknown and recognized his developmental needs.

One of the most important findings of this study was that the key to achieving social competence and independence for the hemophilic boy is a father (or father figure) who recognizes his maleness or who does not show concern about his activities. Among our "good adjustment" group, fathers were remembered as either permissive or indifferent, but among the "poor adjusters" (classed as dependent-unemployed, and usually living in the parents' home), overprotection from both parents was commonly described.

Childhood Experience

"Can my son have a normal personality development in spite of his hemophilia?"

This is one of the first questions asked by parents of a hemophilic child. Recent research and theory in behavioral science would indicate that the answer to this question is influenced by many factors.

In our own research, the elements regarded by hemophiliacs as most strongly influencing their personality development when young was the parents'

attitude about permitting normal childhood play. Whether special provisions made within the family for the sick child encouraged or played down a sense of difference was also highly important. While these factors were not the sole contributors to adult adjustment, they were the chief factors stressed by our subjects.

Most of our subjects had been diagnosed as hemophiliacs very early in life and reported they had "always" known they were "different" from other children. The degree to which they felt different did not correlate with the number or severity of illness episodes they had experienced, but was associated with the degree of isolation they had experienced or of restriction from kinds of activities boys usually enjoy. Most of our subjects reported they had been capable of setting their own limits of activity "by the age of 6 or 7" because the consequences of injury were so painful. They could not protect themselves against spontaneous bleeding, but could and did avoid body contact injuries. In remembering injuries which occurred when they "broke a parent's rule," they said that often it was not the prohibited activity *per se* that brought about painful consequences, but the tension caused from disobedience. They also reported that as adults they were similarly accident prone when under tension, but competent in self-protection at other times.

Another key to feeling "male" lies in sharing experiences with other boys from preschool age until adulthood. A large number of our sample of "good adjusters" felt that their parents encouraged them to join with other children, while most of the "poor adjusters" recalled parental opposition. If not permitted to join other children because parents consider the risk too great, the hemophiliac, who like any child wants to be with other children, internalizes the concept of being "totally different" instead of a child who has a difference but also has many likenesses to his peers.

Even when very young, the child with a *visible* handicap can be accepted by other children without being expected to join in all their activities; but the "normal appearing" child has no visible excuses. Since most young boys' play is gross motor activity, the issue of how far the hemophilic child can go is posed early and decisively.

The key problem for parents of hemophiliacs is in drawing a fine line between necessary caution and harmful overprotection. When our subjects were asked what advice they would give to parents of hemophiliacs, many stressed the importance of developing independence by allowing the child to learn himself what his limits are. One subject advised, "Try to teach him self-discipline and give him lots of love." Another commented, "I knew what I could and couldn't do, but my parents felt my body should be wrapped in cotton-wool, even if it meant missing all the good times kids need."

School Experience

The years from age 6 until the teens were recalled as their hardest by our subjects. In this period they derived little gratification from being good students, since their peers placed a much higher value on other accomplishments, especially in athletics. Most of our subjects considered themselves scholastically advanced as children because they read a lot when they could not play. On the other hand, they had attended school only irregularly, and had obtained little satisfaction from their schoolwork. Those who had gone to schools with large structured classes had had more difficulty in school adjustment than those who had attended one-room schools. The latter, being in classes with children of various ages and grades where students were expected to learn different things, did not feel conspicuously different when the teachers individualized their work for them.

The grade school years were usually evaluated by our subjects according to how much activity they missed and how excluded they had felt. If the parents restricted or forbade after-school play, the youngster felt alienated from his peers. But the child who because of his parents' intention or indifference was allowed to join other children had a chance to identify with other boys.

Three men in the sample who had not attended school beyond the third grade are employed and finding satisfaction in adult roles, and so are classed with the "good adjusters." All three reported that when they were children, their parents had expected them to act like boys even though they were too ill to go to school.

The following case stories illustrate contrasting parental approaches and their effects.

Mr. P is a pale, thin, attractive man with no apparent physical deformities. He lives with his widowed mother and his married sister and her family. He spends his day viewing TV, reading, or "just doing nothing but watching people pass by on the sidewalk in front of the house."

When he was a child, Mr. P was never expected by his parents to do anything except watch. He was not allowed to play with other children for fear he would get hurt. By the time he was 6 or 7 he was afraid to join the neighborhood boys

because he did not know how to play their games with them. Gradually he withdrew to watching through the window.

At age 10, Mr. P was enrolled in school for the first time at the recommendation of the local school authorities, but was so frightened by the "big kids" that he never returned to class. His parents made no effort to send him back. He received what education he got from a home teacher and from correspondence courses in accounting and bookkeeping. When he was 24, he tried to work for 3 days but quit because the office crew were not especially cordial and because his parents felt he should not "push" to get to the office by 9 a.m.

Now at 32, Mr. P feels that life is passing him by. He has nothing to do and no interests. His family still tends to watch him if he tries to sweep the porch or carry out the garbage because they fear he will hurt himself. He wishes he had been expected to play outside, to assume household chores, to attend public school, to develop active hobbies, instead of being encouraged only to protect himself physically.

. . .

Mr. A, age 35, walks with a pronounced limp and carefully lowers himself into a chair. He came to the interviewer's office after working hours. He is a tool dyer and has been employed in the same firm for the past 9 years.

Mr. A described his childhood as "never having a parent at home." His father seldom "bothered to come around" and his mother "was always working or out." He had many episodes of bleeding into weight bearing joints as a result of which he often used crutches. He did not attend school because no "truant officer bothered us after the years I had been in the hospital" and my parents "weren't around to make me go."

Mr. A remembers waiting each day for 3 o'clock to come around, for then the neighborhood boys would be home and he could play with them. He liked fishing and sliding down sand hills on boxes, but best of all he liked just being with his "buddies."

Before he reached his teens, Mr. A was "hanging around a garage" with older boys and developing a skill in fixing cars. Once in a while he helped his father, who was a mechanic. Since crawling under cars was too difficult for him, he gradually converted his interests to tools. Though he had no formal training as a tool dyer, he made himself into a tool expert, and is now proud of his earning capacity and his productivity.

Even though Mr. A's "indifferent" parents did not provide him with much love and security, he became an apparently competent person because they did not smother him or isolate him from social contacts.

Teenage Experiences

Among physically normal children, adolescence is frequently an emotionally painful and difficult period, but, as Beatrice Wright [2] has shown, this is not always true of the handicapped child.

Our subjects generally found the teen years easier than their earlier years. Many of them made their first fully reciprocal and satisfying friendships then. Formerly, play activities were chiefly physical, but in their teens many of their peers had hobbies and interests which they could share—stamp collecting or motor cars, for example. Scholastic accomplishment now had rewards, since in some high schools the "bright" student with a broad range of knowledge may attain status.

The feelings about being "different" did not disappear but did diminish as the hemophiliacs grew older and found more bases for social relationships. Gradually they became aware that other boys were also feuding with their parents over limits on independence—hours, use of the car, family participation—and this was reassuring because it helped them experience a bond with their contemporaries.

In the course of adolescence, peer group approval became as important as paternal approval had been earlier. If allowed to mix with other teenagers, the hemophiliacs tended to adopt the peer group outlook on employment, schooling, and other topics.

Cars had an even greater meaning to the hemophilic teenager than to his unhandicapped compeer. The democracy of wheels served both as a leveler and as an opportunity for increasing social status. There were many more drivers among those of our subjects classified as "good adjusters" than among the "poor adjusters." In addition to its practical value, driving seemed to help the handicapped teenager to express his desire to be like and to spend time with his peers.

Vocational Counseling

Gains from having had professional vocational counseling were noted by some of our subjects, but the timing of counseling interventions was often regarded as inappropriate. Many of our subjects had not received help in vocational planning until they were in dire need of employment and were seriously disadvantaged by their lack of skills or education. Vocational counseling had been beneficially used by 8 of the 40 hemophiliacs interviewed, but the most helpful counseling was reported as having been started during the junior high school years (ages 12–15). During this age period, the youngster could accept a trainee or student status because he was at an age when young people are expected to be financially dependent and when school attendance is the usual routine of his age contemporaries regardless of their financial status. The hemophiliac who did not have vocational discussions until he was in his late teens often felt then that he was too old to start a long educational program and went into unskilled work. Many of our subjects commented that "they [the counselors] waited until it was too late for me to change."

Help in early vocational training and planning was regarded by our subjects as necessary in a total treatment program for persons with a chronically limiting disorder. They described the ideal vocational counselor as one appropriately informed both about job prerequisites and potentials and about the limits imposed by specific diseases. However, they stressed the fact that *the self-image of the patient has to include being potentially employable before he can respond to vocational guidance and training in a realistic way.* Again, we were made aware of the family's great influence on individual potential for independence and competence.

Our subjects included many young adults who had found work on their own, some of whom recognized they had made poor job choices because of lack of guidance. Also included were hemophiliacs who had received vocational guidance and training, but who had not sought employment because they felt unable to work in the field of their training. Isolating occupations, such as watch repairing, were reported to be bad choices because the handicapped person needs to make social contacts through his work experience; moreover, for hemophiliacs constant sitting, in a confined area, may be physically damaging. Self-employment, after enough training to permit work at a livable level in occupations in which frequent absences would not matter, was often cited as ideal for the hemophiliac. Twenty percent of our subjects had attained this goal.

Here is one success story:

Doctor Z is a research chemist with a commercial drug firm. As a young child he used crutches occasionally and was confined to bed frequently, but he "made it through high school." His family expected him to help on the farm, and he managed both chores and schoolwork. During high school he showed interest and ability in the physical sciences, and the school guidance officer encouraged him to compete for a scholarship to college. The undergraduate course took him 8 years due to dropouts from illness, and the graduate work even longer, but he is now well established.

Doctor Z supervises a research laboratory and explains that he can "supervise by telephone for a few days when necessary." Married, with young children, he assumes a responsible position in the home, in the community, and on the job.

Doctor Z advises young people with chronic handicaps to expect to reach educational goals more slowly than others, rather than to take on the unrealistic burden of trying to keep up with other students.

Rehabilitation and Counseling

Most State departments of vocational rehabilitation extend services to handicapped persons who have reached the age of 16; but many persons who have had lifelong handicaps do not make application for services until much later in life. We saw hemophiliacs who were unaware of this source of help, who felt too defeated to try to qualify for training, or who were likely to continue to be dependent the rest of their lives because they were unable to visualize a different role for themselves. With some intensive help, these men might be rehabilitated to gainful employment, but at their age changing a dependent to an independent self-image through counseling is a long and difficult process.

Complex life adjustment problems obviously confront every hemophiliac as well as other chronically ill persons. If a professional counseling service were readily available at the time of diagnosis and thereafter, parents would have the opportunity to explore their reactions to the handicapped child, to gain emotional support during crises, and to learn to plan and provide a home climate that fosters independence and growth. This preventive approach would reduce the necessity for rebuilding a damaged self-image in adulthood. Somewhere within our public and voluntary efforts for handicapped children, we should be able to find the wisdom and resources to implement it.

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[1] Canadian Hemophilia Society: *Hemophilia Today.* Montreal, Canada, Mar. 1, 1962.

[2] Wright, Beatrice A.: Physical disability: a psychological approach. Harper & Bros., New York. 1960.

I think that the major trouble with youth today is an all-compelling sense of urgency; a fear that if you don't see it all, do it all, try it all, in a very short time, you will never get the chance to do it or see it or ANYTHING.

B. C. C., age 17, New York, in a letter to the 1960 White House Conference on Children and Youth.

A report from Poland . . .

TREATING CHILDREN TRAUMATIZED BY HOSPITALIZATION

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DURING the past 7 years, the authors of this report have gained considerable experience in the prevention and treatment of the maternal deprivation syndrome in hospitalized infants and young children in Warsaw. This syndrome, sometimes called "hospitalitis," is well-known to persons who have observed young children in institutions and hospitals. It consists of a failure to thrive physically and in social and psychological development, and is a result of the exposure of the hospitalized child to numerous traumatic factors and of the frustration of those inborn needs which are normally met in a family environment. In extreme cases it may be manifested as a general marasmus, or wasting away.

Our experience was gained during clinical work with children in the Institute for Mother and Child, a hospital and research center in the Premature Clinic of the Medical School in Warsaw. During these experiments, material was gathered on the clinical history and detailed psychological examination of 211 children, including 78 children with a severe maternal deprivation syndrome hospitalized in the Premature Clinic's Department of Developmental Pathology and 60 children examined in residential crèches. One of the authors (Izabela Bielicka) gained additional experience with such cases in carrying out her responsibilities as state consulting pediatrician. From these experiences, as well as from data in the professional literature, were formed the theoretical basis as well as the practical outlines for child care during hospitalization which the Department has adopted.

In the Department of Developmental Pathology we see children from a few months to 3 years old who are admitted for care mainly because of severe malnutrition after a long hospital or institutional stay. The technical team consists of two physicians and two psychologists working in close collaboration. The same team works also in the outpatient clinic. In addition, there is a team of 7 nurses, each caring for 10 or 12 children.

The children are cared for in four glass-walled wards and a fifth room which is a common recreation room. In addition there is a wide corridor where they can also run and play. In summer, the children spend 2 or 3 hours daily on a veranda or in the garden. In these facilities the Department trys to meet the children's basic needs—for good nutrition, for sleep, for protection against fear and physical pain, for a sense of security, for mothering, for active exercise and exploring, for visual, auditory, kinesthetic, and touch stimuli, and for play and freedom of movement. We try to enrich the hospital environment by ensuring a diversity of adequate stimuli.

Nutrition

Nutrition is considered a priority problem in the care of our patients. Most of them suffer from anorexia (lack of appetite) and negative reactions to feeding, such as vomiting or other defensive reactions against food. We insist that the feeding of the children should, as far as possible, be carried out always by the same person. During bottle feeding the infant is held on the feeder's lap, thus providing for an association of feeding with a close physical and emotional contact between the child and the adult who is substituting for the mother.

Because of the functional deficiency in digestive glands, especially the pancreas, in many of these patients, the diet is protein rich and often flavored with horseradish, mustard, or mayonnaise. The quantity and quality of the food is regulated by "self-demand," especially during the most severe period of digestive disturbances. As rehabilitation progresses the children become adapted to a more regular regime of feeding.

In our practice we frequently have observed children whose initial severe anorexia becomes transformed into its opposite, wild hunger and fear of food withdrawal. During this period of insatiety the children are permitted to eat as much as they wish, and even to fall asleep holding a reserve piece of toast. This permissive system eventually results in the child's forming good permanent eating habits.

Sleep

We try to ensure our patients undisturbed and deep sleep. Uninterrupted sleep lasts from 7 p.m. to 6:30 or 7 a.m. The morning toilet bathing and room cleaning are performed at 6:30 a.m. by the night and day duty nurses together. During the daytime nap the patients sleep out of doors or at least by open windows. Personnel are forbidden to

Hospitalized children on an improvised slide at the Institute for Mother and Child in Warsaw.

interrupt a child's sleep for treatment or examination.

We believe that a close physiological interrelationship exists between the activity during the waking period and the intensity or quality of the sleep. Therefore, the daytime naps are alternated with periods of intensive wakefulness, stimulated by active play out doors under friendly adult supervision.

Protection Against Frustration

Protection against frustrating factors such as pain, fear, and feelings of isolation is an important part of our nursing system. Friendly and delicate handling during the medical examination and nursing care are regarded as especially important. Coldness, overwarmth, or violent movements of the nurse during diapering, shaking the child or making noise while he is sleeping, forcing him to eat, and, above all, not responding to him during a prolonged period of crying are avoided as repeated microtraumas which lead to discomfort and maladjustment of the child during the stay in the hospital. Technically efficient nursing is not enough to eliminate the damage of hospitalitis. The only way to ensure adequate care of a child in a hospital is to create an emotional bond between the adult nurse and the young patient, thus combining nursing and mothering.

During their waking periods the children are together in a play room and this helps ward off feelings of isolation or other fears even when the "substitute mother" is absent.

The lack of constant care by the mother or a mother substitute cannot be compensated for fully in hospital conditions even if the staff remains mindful of the psychic requirements of the children. In this respect our experience is in accord with the professional literature on this subject and demonstrates that, while drastic forms of hospitalitis may be treated successfully, the child may attain full rehabilitation, especially development of his social personality and speech ability, only when fitted into normal familial home life.

Conclusions

Our observations have resulted in the following rules for child care:

1. The child should be hospitalized only in cases of unavoidable necessity.

2. Orphans or abandoned children should, as early as possible, be placed with families for adoption or foster family care. Foster family care has recently been introduced into Poland by the Ministry of Health and Social Welfare.

3. The hospital doors should be kept open to the mothers of child patients. In our hospital the mothers are encouraged to spend as much time as possible with the child, a policy we have found very helpful in treating the child. We have attained good cooperation between mothers and personnel of the clinic and have not had any infectious diseases introduced as a result of the mothers' frequent visits.

4. In the mother's absence from the hospital, the child should be given into the care of a staff member who serves as a "substitute mother." In our hospital the substitute mother is usually a nurse, but in difficult cases this function is performed by a psychologist. The task of a substitute mother is to build an emotional bond with the child. We have observed surprising improvement in the development and well-being of children after such a bond has been created, and so consider such substitute mothering as basic to our treatment.

5. The nurses' training should include the development of maternal personality traits such as sensitivity to various emotional states in the child, sensitivity to pain felt by the child, the ability to make independent decisions, and the ability to make adequate observations of the child. We regard the ability to form attachments to the patient—a readiness for mothering—as the most important trait of all. According to our experience, this trait may be developed to a great extent through bringing influences to bear which encourage the nurses to demonstrate their own initiative and spontaneous friendliness to the children.

6. The functional needs of the child such as the need for motor activity and for diversified play must be taken into account and satisfied. We should like especially to stress the need for kinesthetic and touch stimuli, which dominates all other needs in early life and is met by cuddling and petting the child. Because we have found that the lack of such stimuli may cause the appearance of early forms of emotional disturbances, especially in premature babies, we try to ensure that the infants spend as much of their waking time as possible on the nurse's lap. We have observed marked improvement in cases of severe psychomotor regression in weak and emaciated children after they have been regularly held and cuddled by a substitute mother.

All these methods used in the Department of Developmental Pathology have proved effective in the rehabilitation of 78 cases of severe psychosomatic disturbances induced directly or indirectly by a period of institutional stay in hospitals or children's homes.

Stimulated by personal attention this hospitalized child takes a lively interest in what he sees.

An essay review . . .

SOCIAL PLANNING FOR CHILDREN AND YOUTH

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IN his recently published book, "Planning Community Services for Children in Trouble,"* Alfred J. Kahn applies the most recently articulated ideas about community service systems for children to specific experiences of States and local communities. While adequately presenting the theoretical formulations which have emerged from academic circles, he, at the same time, takes into consideration the simple fact that most practitioners and interested laymen are focusing on the day-to-day tasks of rendering services to people who need them. Thus he spans the distance that sometimes exists between the academicians and those on the firing line.

The message carried throughout the book is that a "policy vacuum" exists in planning for children in trouble. The author presents this by illustrating the confusing and sometimes conflicting policies in community programs conducted in the interest of children's welfare. He clearly relates the policy needs regarding children to broader policy considerations involving the welfare of the total population.

The search for the focal point in such policy formulations is complicated by the way in which communities have delegated certain responsibilities for policy to community institutions; and thus we often find a condition that permits agencies to define community policy based on agency function rather than on community need. Dr. Kahn discusses the way in which such circumstances evolve.

However, while placing a timely stress on planning to insure the quantity and quality of services needed for children and illustrating the numerous variations in style of planning in community and State approaches, Dr. Kahn does not deal in depth with the ingredients of the planning process nor with any set of assumptions other than those reflecting a desire to improve the lot of children for humanitarian purposes. He seems to accept an innateness in our social system for circumvention and evasiveness in confronting causal conditions. For example, in his discussion of the tendency to bureaucratize service systems, he says:

> In a complex, industrial society, and particularly in its urban areas, the nature of population concentrations, the wide ramifications of needs, the multiplicity of skills required and services offered all lead social welfare programs to that inevitable formal organization . . . which is characteristic of most organizations in the modern world. Wilensky and Lebeaux have reminded us that "red tape, buck passing, inaction, inflexibility," which are ways in which the layman would characterize many of the service problems, are actually pathological manifestations of some of the most basic and valuable features of modern formal organization. In their attempts to achieve efficiency, reliability, continuity, precision, and fairness, organizations are inevitably and increasingly characterized by *specialization . . . hierarchy . . .* an emphasis on *rules . . . assignment of roles to specialists . . .* and *official designation of areas of jurisdiction* for the several roles.

Accountability

Dr. Kahn indicates that these tendencies are inevitable although some islands of simple and informal organization do exist. The process of formalization tends to separate the agency and the problem-solving process from the problems and the populations having the problems. Defective service programs are therefore traceable in large part to the "ever threatening psychopathology of bureaucracies" and an answer to this inherent quality of social welfare organization lies in the "organized means for ensuring accountability and service integration."

Dr. Kahn's method of dealing with the concepts of accountability and service integration clarifies his concerns about fragmentation in relation to agency policy. He states that agencies ". . . are instruments of public policy and social control," established to translate basic community concerns into workable programs, and that the practitioners inherit small portions of this community mission of control. However, he maintains that the mission cannot be fulfilled unless the full responsibilities of the community toward the problems are discharged, and that anything that encumbers this process contributes to the fragmentation of services. Presenting a number of examples of accountability devices and instruments designed to prevent encumbering conditions, he reexamines certain

*Kahn, Alfred J.: Planning Community Services for Children in Trouble. Columbia University Press, New York. 1963. 540 pp. $7.50.

concepts of coordination that at one time seemed useful but today, under the present pace and dimensions of social change, seem less effective.

Coordination

Dr. Kahn's method of treating "coordination" is impressive to one who believes that coordination is a word that has been misused in social work for a long time. From experience in working with agencies having responsibility for coordination, this reviewer is convinced that much depends on authority, responsibility, lines of communication, and other factors between the coordinating body and the services being coordinated. To simply cite the need for more effective coordination is much simpler than to detail explicitly the procedures that will bring this about in any particular community. Yet the mechanism for coordination is an important element in reaching an adequate service system.

Largely because of the stresses generated by interaction between cooperating agencies in States and communities, long-term permanent coordinating agencies have found it difficult to keep pace with the changes in community organization indicated by rapid social change. The hiatus between service systems and consumers of service, widened by the growing dollar gap betweeen middle and low income segments of the population (and the apparently growing disparity between income levels of white and nonwhite families), puts new dimensions into the meaning of coordination. At the same time, it calls for different, imaginative uses of instruments of coordination, such as money and the methods employed for its allocation. And, it raises new questions about the composition of local "power structures" and their systems of delegating decision-making responsibilities.

Although Dr. Kahn does not elaborate on such questions, in his discussion of planning he obviously recognizes their pertinence to his conclusions.

Planning

The familiar plea for planning runs throughout the book. In illustrating different approaches to State and local planning, the author underscores the need for more effective approaches. However, here there is a rather serious omission.

The most difficult problem in planning is the construction of the means through which communities can achieve the working relationships required for implementation of a broad plan. In fact, the discovery and analysis of these means cannot be separated from the total package of planning responsibilities. Therefore, a discussion—missing in this book—of the relationship between the economic and political facts of life to efforts to enhance the welfare of young people would seem to be relevant. An examination of the broading in this book—of the relationship to a broad community policy for youth, could reveal some interesting features of community values as they are translated into programs.

Because all programs are ultimately translated into dollar costs, an examination of the question of whether the short-run business interests that form a large part of the local community economic base are inherently disruptive of social planning would be beneficial. Similarly, with much of public policy determined by political functionaries, the author's stress on planning needs might be better understood if accompanied by some connecting analyses of political processes at the State and local community levels. The balances which must be achieved between varied forces in a community in order to implement a welfare program must include balances within the political and economic segments of the community.

Dr. Kahn's final note about planning—that "consumers of service" have a contribution to make—might well have been presented in the light of the insistence today on the part of many consumers on their right to a place at the decision-making tables. Whether planning is addressed to physical or social community needs, planning for and around rather than with the consumers of service may, in the long run, be more costly than the traditional, fragmented approaches to social planning.

On Delinquency

One of the book's most impressive discourses deals with the various theories of delinquency causation and prevention existing today. Avoiding an entanglement with the relative merits of these, the author states: "Clearly, many of the theoreticians are accounting for different aspects of the phenomenon, for different delinquencies." As he discusses programs for intervention, he takes into account many etiological theories, stressing that systems of classification of delinquents or delinquencies cannot be the sole basis for prescribing the most appropriate form of community intervention.

Dr. Kahn seems to support the current trend toward the development of broad, comprehensive approaches to the problem with carefully structured methods of program evaluation. In referring to "ultimate, intermediate and immediate levels" of prevention, he notes the impact of broad social forces. But he considers the "ultimate level" outside the scope of the book, and places emphasis on a discussion of those levels responsive to local and State action. Thus, having built a beautiful case for the integration of delinquency prevention and control programs with programs designed to affect trends, such as mobility and urban growth, he confines his attentions to the former.

In general, one is impressed with the potential utility of Dr. Kahn's work to all concerned with playing a useful role in the community's responsibility for the young—whether through the courts, social agencies, schools, community groups, health services, or at home. Many writers have dealt with the same delicate subjects only through negative criticism of institutional services and functions. By contrast, Dr. Kahn leaves the impression that these are part of a predictable developmental pattern calling for "firm public policy and support" to tip the balance toward progress.

BOOK NOTES

THE MULTI-PROBLEM FAMILY: a review and annotated bibliography. Benjamin Schlesinger, with essays by John C. Spencer, and Joseph C. Lagey and Beverly Ayres. Florence Strakhovsky, Editorial Consultant. University of Toronto Press, Toronto, Canada. 1963. 173 pp. $4.

Out of the literature on troubled, dependent families—of Australia, Belgium, Britain, Canada, France, the Netherlands, and the United States—the author, assistant professor, School of Social Work, University of Toronto, has compiled an annotated bibliography, introduced by two essays that attempt to give perspective on such families.

The first of the essays, by a professor at the same school, traces development of the concept of "the multiproblem family" as well as variations and some common denominators in the approaches of these nations to defining, treating, and giving services to them. The other essay, which lists programs in 143 communities in North America, is by two staff members of the Community Chest and Councils of the Greater Vancouver (B.C.) Area.

The items in the bibliography, which go up to November 1, 1962, are grouped according to country, then alphabetically by author.

FAMILY AND MENTAL HEALTH PROBLEMS IN A DEAF POPULATION. Edited by John D. Rainer, M.D., Kenneth Z. Altshuler, M.D., and Franz J. Kallmann, M.D., with the assistance of W. Edwards Deming. Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, New York. 1963. 260 pp. Distributed upon request; mailing charge $1.

The pronounced lack of knowledge among the deaf about the workings of heredity emerges from the mass of facts presented in this book by an interdisciplinary fact-finding team that ventured during 1955–62 into the family and mental health problems of the deaf in quest of a design for a dynamic, integrated guidance program. The three-pronged project—in research, psychiatric guidance, and guidance workers training—was conducted at the Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, with the support of the U.S. Office of Vocational Rehabilitation (now the Vocational Rehabilitation Administration).

It was carried out by staff in clinical, social, and genetic psychology, audiometry, cytogenetics, psychology, and population statistics. Their findings, based on a study of persons over 15 years of age deaf from birth or early childhood in New York State and deaf twins in the eastern part of the United States, make up the bulk of the book's 19 chapters.

Among the many findings were: that nearly 10 percent of all children born to the deaf subjects are themselves deaf; about 15 percent of the congenitally deaf say they prefer to have children with normal hearing, yet they are apt to choose deaf mates; deaf children diagnosed as neurotic mostly came from families without other deaf members.

The fourth part of the book sums up and recommends, among other things, specialized psychiatric treatment facilities, properly integrated sex education throughout the school years, and individualized guidance to meet disordered behavior in the deaf; and careful community research planning, self-critical service, and training new personnel to prevent such behavior.

HOSPITALS AND CHILDREN. Edited by James Robertson. International Universities Press, New York. 1963. 159 pp. $4.

A 2-year-old in a hospital children's ward clings "like a little animal" to his parents, monotonous hopeless sobs change to piercing screams as his parents prepare to leave; a little girl sobs "Mummy, mummy"; and other children thus "suffer in a way that should make our civilized society ashamed of its cruelty." These are some of the images conjured in this book's 12 chapters of documented argument against separating young children briefly hospitalized from their mothers.

The book is constructed out of letters on hospital practices and attitudes from British parents who had children in hospitals. The letters are threaded together with a running commentary by the author, of the Tavistock Child Development Unit, London. They report on mothers' experiences of rooming in with their hospitalized children, unrestricted visiting, restricted visiting and associated difficulties, staff attitudes, and children's reactions after return home. In a concluding chapter called "A Blind Spot of Our Time," the author comments on the importance of implementing the recommendations of the Platt Report of 1959, described as having demonstrated the seriousness of separating the young hospitalized child from his parents.

WORKING WITH CHILDREN IN HOSPITALS: a guide for the professional team. Emma N. Plank, with the assistance of Marlene A. Ritchie. The Press of Western Reserve University, Cleveland, Ohio. 1962. 86 pp. $3.50.

Blending some principles of child development with lessons learned while operating a child-care program in the pediatric ward of a general hospital, the author has compiled this guide for persons working with children in hospitals. Beginning with the children's psychological state on entering the hospital, the book discusses spontaneous interactions and withdrawal among hospitalized children, ways of preparing children for surgery and helping them to work through their feelings afterwards, psychological handling of death on the ward, and play and learning activities in the hospital. Appendices include a "Letter to Blackie," an illustrated pamphlet that helps prepare children for surgery.

WORKING MOTHERS AND THEIR CHILDREN: a study for the Council for Children's Welfare. Simon Yudkin and Anthea Holme. Michael Joseph Ltd., London, England. 1963. 199 pp. 21 shillings.

In this profile of the working mother in Britain and her children—the prod-

uct of discussions and research in which a number of British universities took part—the authors attempt to illumine a corner of life toward which they contend prejudice rather than fact has shaped public attitudes.

The book's eight chapters examine trends that have led mothers to take jobs, the attitudes of employers and the mothers themselves, arrangements for the children's care, and the effects of mothers' working on their children's growth.

According to the authors, working mothers of children 15 years of age and under make up one-quarter of the women in Britain's labor force and are essential to the economy.

The vast majority of mothers of preschool children make arrangements for child care that are adequate, claim the authors, who exhort officialdom, however, to consider the need for substitute care of preschool children of mothers forced to work and thus possibly forced to accept inadequate child care; and for comprehensive planning for older children to occupy them after school and during holidays.

Also noted is that the mother's working may in some instances mean a healthier family life, especially if the work replaces the father's excessive overtime. The authors urge more research about mothers who are sole supporters; industrial shifts to suit working mothers; and more practical help rather than criticism from educators, health visitors, and social workers, to mothers contemplating work.

BIRTH TO MATURITY: a study in psychological development. Jerome Kagan and Howard A. Moss. John Wiley & Sons, New York. 1962. 381 pp. $8.50.

Studying this report of a 30-year longitudinal study of stability of behavior are what the authors call "tentative bits of evidence" linking behavior in childhood with personality and interests later in adulthood. The authors, both research psychologists, studied 89 persons intensively from birth to 14 years and periodically thereafter, ending with a personality assessment of 71 subjects as adults.

After outlining their methods of assessing the adults for conceptual styles and intellectual functioning and examining the results against the data on these individuals as children, the authors identify islands of continuity in passivity and dependency; aggression, competitiveness, achievement, and recognition; heterosexuality; and social interaction. They also examine the effects of maternal practices on the child's development and other sources of conflict and anxiety.

In psychological tests reactions of the heart or the palm and interpretation of an ink blot are subject to complex processing and censoring by the individual and are thus no shortcuts to direct assessment of motive or anxiety, the authors maintain.

Guides and Reports

YOUTH TAKES THE FIELD. Committee on Youth Services, National Social Welfare Assembly, 345 East 46th Street, New York 17. 1962. 16 pp. 30 cents a single copy; 25 cents on orders of 25 or more.

Addressed primarily to youth 15 to 19 years of age, this booklet suggests ways to participate in community activities and records the priorities for action recommended by the youth delegates at the 1960 White House Conference on Children and Youth.

MEDICAL RESPONSIBILITIES FOR THE DISPLACED CHILD: report of the 43d Ross Conference on Pediatric Research. Charles D. May, M.D., editor. Ross Laboratories, Columbus 16, Ohio. 1963. 67 pp. Limited quantity free on request from Ross Laboratories.

These 13 papers presented at a 2-day conference held in June 1962 under the auspices of the New York City Department of Health and the Department of Pediatrics, New York University School of Medicine, emphasize the medical needs of children from families disrupted by illness, separation, death, or divorce, children of migrant workers, children in public welfare programs, and children in times of war or natural disaster.

NEED A LIFT? To educational opportunities. (12th edition, revised Fall 1962.) The American Legion Education and Scholarship Program, Americanism Division, Post Office Box 1055, Indianapolis 6, Ind. 1962. 100 pp. 25 cents. Copies available from The American Legion.

This annually revised handbook, published as a part of The American Legion's Education and Scholarship Program, contains sources of career and scholarship information for young people, including information on State laws that are offering educational benefits.

THE NEGRO AND EMPLOYMENT OPPORTUNITIES IN THE SOUTH. 1. A report based on a survey by Art Gallaher, Jr., Department of Sociology and Anthropology, University of Houston. Houston Council on Human Relations, 3605 Fannin Street, Houston, Tex., and the Southern Regional Council, 5 Forsyth Street NW, Atlanta, Ga., November 1961. 22 pp. 2. A report based on a survey by the Chattanooga Council for Cooperative Action, Major J. Jones, Research Coordinator. The Chattanooga Council, 601 East Ninth Street, Chattanooga, Tenn.; and the Southern Regional Council. February 1962. 16 pp. Publications free upon request from the local councils and the Southern Regional Council.

The first two of a projected series of employment studies in southern cities, these publications report on employment discrimination against Negroes in Houston and Chattanooga, showing that discrimination begins for the Negro youth long before he applies for his first job, because of unequal education and training in segregated schools.

HERE AND THERE

Freedom From Hunger

At midpoint in its 3-year-old Freedom From Hunger Campaign (see CHILDREN, March–April 1963, p. 83), the Food and Agriculture Organization of the United Nations (FAO) sponsored the World Food Congress in Washington, D.C., during 2 weeks this past June. About 1,100 delegates from more than a hundred countries attended the Congress, where they exchanged information and ideas on world food problems—notably the race between soil fertility and human fertility.

Problems associated with this race dominated the plenary sessions: Dr. B. R. Sen, director-general of FAO, estimated that to meet the minimum food requirements of developing countries by the year 2000, food output there would have to be augmented three or fourfold; United Nations Secretary-General U Thant pointed out that increasing the food supplies of these countries must be paralleled by stimulating the economy to augment the people's purchasing power for buying nutritious food; and the British historian Arnold J. Toynbee called on all nations to act as "a single world-wide unit" for producing and distributing food and for voluntary regulation by families of the birth rate to match "the already achieved reduction of the death rate," and warned that science cannot increase the food supply ad infinitum.

Dr. Candau, director-general of the World Health Organization, observed that, for the most part, malnutrition underlies the high death rate of children under 5 in some areas of the world, a fact he said was not reflected in mortality statistics since death certificates show the killing disease or ultimate condition invited by malnutrition but not this basic cause.

Other speakers made these points:

- While the regions now most deficient in food are where future populations are likely to be greatest, the world's land and resources are ample for future populations until the end of the century if properly used.
- Illiteracy among farmers and impractical, nonfarm-oriented education of farm youth in some areas of the world hinder improvement in farm methods.
- Rather than donations of surplus foods, developing countries need to have the knowledge, techniques, and tools that made those surpluses possible.
- The efficient and substantial growth of livestock industries in developing countries is hindered by insufficient demand for meats because of low per capita incomes.
- In advanced countries, food faddism, diet neurosis, and superstitions about food can lead to bad nutrition.
- Governments ought to set up units to advise people on nutrition and good eating habits.

Out of the discussions that took place in several technical work groups of the Congress emerged recommendations that governments keep in mind that good nutrition is essential for the health and well-being of their populations, and that they base their policies on the recognition that food is a means to health, efficiency, and well-being rather than "some edible stuff that temporarily suspends the agonizing qualms of hunger." Also proposed was that supplementary feeding programs for children planned by governments be more clearly defined as to targets and geared to local conditions so that they reach those needing them but not now included.

Permeating both plenary meetings and discussions was a concept expressed in various ways: that freedom from hunger is man's fundamental right and that the persistence of hunger, malnutrition, and poverty—among more than half of mankind—is unacceptable morally and socially and is incompatible with the dignity of human beings.

—Eleonora Chatty

About Glue Sniffing

Concern over an apparent increase in the incidence of the intentional inhalation of plastic cement by children and teenagers has prompted the Children's Bureau to gather available information on this practice, known as glue sniffing, and its effects on the young people who engage in it. The practice first came to public attention in 1959, and in the following 2 years had engendered sufficient concern to be mentioned at the White House Conference on Narcotic and Drug Abuse as a hazardous teenage fad necessitating a community education approach. It has received considerable attention in the news media and some in medical journals, the latter usually warning against arousing the curiosity of the young by giving this practice, believed to be a fad, too much publicity.

In an article in the *Journal of the American Medical Association* (July 28, 1962), Drs. Helen H. Glaser and Oliver N. Massengale have described the effects of glue sniffing as varying from a mild "jag" to drowsiness, stupor, or unconsciousness, and have reported that the practice sometimes leads to nausea, loss of weight, irritability, irritation of the mucous membranes of the nose and mouth, distorted vision, headache, and dizziness.

The toxic substances most commonly present in plastic cement are acetone and toluene. Other substances sometimes included are benzene, carbon tetrachloride, methyl ethyl ketone, amyl acetate, butyl acetate, ethyl acetate, and butyl, all solvents commonly used in paint products and not deemed toxic in proper use. Some manufacturers are endeavoring to develop a substitute for these toxic solvents. The Hobby Industry Association of America which estimates that 15 to 20 million young people enjoy plane construction is also testing for a nontoxic solvent.

Other efforts to control the practice thus far have included conferences between public health authorities and representatives of the glue manufacturing industry; in a few rare instances, specific legal restrictions either through city ordinance or State law to prohibit the practice; and vountary restriction of sales by merchants.

No reliable statistics on the total number of young persons indulging in glue sniffing are available, nor has any laboratory study been reported of any considerable groups of adolescents who engage in the practice. The one reported death associated with the practice in 1962 was of a 15-year-old boy who had placed a plastic bag containing the contents of a tube of glue over his head, and who may have died of suffocation

rather than from the toxicity of the inhalant. However, a report of the National Clearing House for Poison Control Centers, Public Health Service (February–March 1962), reports that the liver, kidneys, bone marrow, and nervous system can be affected by the inhalation of volatile solvents.

—Alice B. Freer

Handicapped Children

The Speech Therapy and Audiology Departments of the Children's Hospital at Denver, Colo., report finding several consistent factors in the early developmental histories of the 2,000 children seen in the hospital's out-patient department for speech, hearing, or language disorders over the past 10 years. The histories, based on information given by the children's parents, revealed the following similarities in the infancy of these children:

1. They did not have strong cries.
2. They were too quiet and good, or they were very fussy and difficult to care for.
3. They drooled more and for a longer period of time than was normal.
4. They had difficulties with sucking and sometimes did not swallow easily.
5. They were not interested in noise-making toys.
6. They were less responsive to voices.
7. They were slow to laugh aloud, coo, and babble.
8. They were slow to attempt smiling.
9. They had digestive difficulties with numerous changes of formula.
10. They were slow in physical and visual responsiveness.

During the past 3 years the hospital's Speech Therapy and Audiology Departments have developed and tested a chart, called the Communicative Evaluation Chart, to help pediatricians and speech and hearing specialists make quick appraisals of a child's development of communication abilities from infancy to 5 years of age.

Mental Retardation

Between July 1, 1962, when a program to detect phenylketonuria in newborn infants by using the Guthrie blood drop test first began, and August 1, 1963, about 240,000 babies were screened for the disease and 24 cases were uncovered. The affected infants were placed on a diet calculated to lower the phenylalanine content of the blood and thus prevent mental retardation.

Present field trials of the Guthrie assay as a screening technique call for collection of 3 drops of blood from 400,000 infants before they leave the hospital and an evaluation of the assay as a screening tool. The program is being carried out under the auspices of State health departments in 29 States, and Puerto Rico with the cooperation of the Children's Bureau. (See CHILDREN, May–June 1962, p. 123).

Since 1956, the Bureau has been working with the State health departments in developing detection and followup diet programs as well as the needed laboratory facilities. As a result of screening activities from 1956 to 1961, mainly with the urine test, 484 children with phenylketonuria were detected and put under dietary supervision.

For Youth

This past spring saw the launching of a pilot project called "A Future for Jimmy," by the Urban League of Washington, D.C., to encourage positive attitudes toward education, life, society, and the future among the city's junior and senior high school students. The project is designed to reach particularly the student of average ability who has difficulties—often serious—and who is culturally deprived and not in trouble but would ordinarily get no help unless he were. Such students are estimated to comprise one-third to one-half of the cities secondary school population.

The project began operations in May with a school-centered phase, offering volunteer tutorial or remedial programs in a junior high school and five churches in the school area, which is characterized by low-income and low morale. Other activities scheduled during this phase included a back-to-school rally during August, counseling potential dropouts, career clinics, vocational guidance meetings, field trips for students to institutions of higher learning, and a "student-recognition day" at the local stadium. The project then proceeded to a home-centered phase—including a summer job program, to give "Jimmy's" family a financial "lift"—and then to a community-centered stage, to help these young people identify with their community and the community with these youth. This phase includes a program of assembly lectures and office visits that bring together students and community leaders who exemplify personal achievement.

The "Jimmy" project is directed by 3 professional workers, 2 social workers and a guidance counselor, aided by an advisory committee of 22 representatives of the social services, the schools, business, the press, the home, and Government. Also, students and faculty members of each participating school help in drawing up plans for the program.

Vaccines

A live virus oral vaccine that protects against all three types of polio was licensed by the Public Health Service in June. The license to produce the 3-in-1 vaccine, combining the three strains of the Sabin oral polio vaccine, was granted to Lederle Laboratories. According to the Service, the product gives some active immunity against all three types of polio after the first feeding and more protection after the second, final dose 8 weeks later.

The three monovalent oral vaccines, developed by Dr. Albert Sabin of the University of Cincinnati, call for one dose each a month apart of each strain to protect against each type of polio. The Salk, killed virus vaccine, also a polyvalent vaccine, calls for three doses, plus a booster shot after a year.

The new product, tested in accordance with Federal regulations, has been found to induce antibodies in at least 90 percent of those who completed the dose schedule.

Public Assistance

Nearly 95 percent of families in State programs of aid to families with dependent children were found eligible for aid under their States' laws and regulations, according to the findings, released in midsummer, from the nationwide review of eligibility conducted in the first 6 months of 1963 by the Bureau of Family Services, Department of Health, Education, and Welfare, in cooperation with the welfare departments of the 50 States. (See CHILDREN, January–February 1963, page 39.) However, wide variations in rates of ineligibility were found among the various States, the range running from no ineligibility (Montana and North Dakota) to 17 percent (West Virginia).

The average rate of ineligibility was 5.4 percent. States' definitions of eligibility vary according to their laws and regulations.

Wide variations were also found in rates of both over and underpayments to eligible families on the rolls. Those States with high rates of overpayments also had high rates of underpayments, the range in both types of errors running from slightly more than 42 percent of all eligible families to less than 1 percent.

Wide variations were also found among the States in average size of caseloads per worker, ranging from 222 cases in Alabama to 52 in New York State. In all but one instance (Oklahoma) those States which had average caseloads per worker of 100 or more had above average rates of ineligibility.

Average costs of administration per case per month were found to range from $27.25 in New York to $3.82 in Arizona. States with high or medium administrative costs ($12 to $14 a month) tended to be among those with low rates of ineligibility, while those with low administrative costs tended to have rates of ineligibility that were above average.

The findings on ineligibility showed that errors in agency practice accounted for larger proportions of ineligibility than intention on the part of recipients to misrepresent or conceal facts. In eight States no cases of intentional misrepresentation were found among the recipients of aid. In only eight States did intentional misrepresentation run higher than 3 percent of the total caseload.

In submitting the report of the findings to a subcommittee of the Senate Appropriations Committee on July 30, Secretary of Health, Education, and Welfare Anthony J. Celebrezze pointed out that because of the weaknesses in policies and procedures found in some States the Department is requiring the States to initiate the following remedial actions: (1) redetermination of eligibility of each case every 6 months, effective July 1, 1963; (2) reinvestigation, including home visits, of a sample of cases each month starting September 1; (3) undertaking intensive reviews with staff of the Department of Health, Education, and Welfare of the States' administration of the program to correct problems brought out by the eligibility study.

The study, which was carried out on the request of the Senate Appropriations Committee, covered 2 percent of the total AFDC caseload, including cross sections of the caseloads of all 50 of the States. It involved a staff of 104 Federal persons from the Department of Health, Education, and Welfare and 2,403 persons from the States.

The study was observed simultaneously by the U.S. General Accounting Office which is issuing a separate report.

. . .

The average annual income per person in households receiving aid to families with dependent children during December 1961 was roughly $408, including the public assistance grant, according to a survey conducted that month by the Bureau of Family Services, U.S. Department of Health, Education, and Welfare, the preliminary findings of which were released last spring. The annual per capita income in 1961 for the United States as a whole was $2,263.

The survey focused on characteristics and financial status of the 910,000 families, including 2,733,000 children who were receiving AFDC payments. Information was gathered on income, educational background, occupational history, parental incapacity, and the legitimacy of the children.

Some other of its findings were:

- The average AFDC family consisted of four persons with an average budgeted need, as determined by the individual States, of $158 per month, or $1.35 per person per day. For all AFDC families in the study month, the average income was $139.78 per month, the gap between State-defined budgeted needs and total resources per family averaging nearly $18 a month. About 45 percent of the families studied were reported to have needs unmet by any income source, the gap between needs and resources in these families averaging $40 a month.
- In 13 percent of all families on the AFDC rolls, the mothers worked, earning an average of $54 a month.
- In the big cities, 63 out of every 1,000 children under 18 were in the AFDC program; in farm areas, 26 per 1,000; and in the suburbs, 17 per 1,000.
- Half of the families lived in crowded conditions (more than 1 person per room); and one-fourth in seriously crowded conditions (averaging more than 1.5 persons per room).
- Of all children in the United States known to have been born out of wedlock, an estimated 21 percent were receiving AFDC assistance, but only about 15 percent needed assistance because of their birth status. The remaining 6 percent were in need because of the death, incapacity, or unemployment of the father or stepfather.
- More than three-fourths of all children on the AFDC rolls during the study period had been born in wedlock.
- More than one-third of the mothers on the AFDC rolls had not completed elementary school; only 16 percent had finished high school.
- The median length of time the families had been on the AFDC rolls was 2.1 years.

Abused Children

The Children's Bureau has drafted and is now distributing suggested language for a State law to protect the physically abused child. Calling for mandatory reporting by physicians and institutions to police authorities of physical abuse of children based on medical findings, the proposed law appears as the fourth of a series of legislative guides prepared by the Bureau to help the States develop sound legislation for the welfare of children.

The new guide grew out of two all-day conferences of lawyers, judges, physicians, social workers, and other specialists that were called by the Children's Bureau during 1962 in response to reports of increasing physical abuse of infants and young children by parents or other caretakers. (See CHILDREN, May–June 1962, p. 123, and September–October 1962, pp. 200–201.) Following through on a recommendation of these groups, the Bureau assembled a small body of technicians to draft suggested legislative wording for use by the States.

In addition to the proposed law, the new guide contains a discussion of the principles behind it. The guide points out that the primary responsibility for meeting children's needs rests with the parents, and that society is obliged to assume this responsibility when parents cannot. Observing that the physician is in an optimum position to form reasonable, preliminary judgments as to how a child's injuries occurred and that when he finds conditions in which physical abuse (as defined in the proposed law) is a likelihood, neither he nor an

institution in which he serves is required to have any discretion in the matter of notifying the appropriate police authority. The proposed law is presented as a first step in protection which should lead to further steps by the community to provide the child with a wholesome environment.

The model law provides for immunity from liability, civil or criminal, for the person or institution reporting; and for nonrecognition in instances of such abuse of the usual physician-patient or husband-wife privilege as grounds for excluding evidence; and makes willful violation of the law's provisions a misdemeanor.

Unmarried Motherhood

Blurred or faulty communication lines among the health and social services and schools were named as a common problem in services to unmarried mothers, during a series of meetings on unmarried motherhood held in five cities and attended by representatives of health and social services, on invitation of Children's Bureau representatives of Region IX. The meetings took place in San Francisco, Honolulu, Portland, Oreg., Los Angeles, and Phoenix—the first meeting during November 1962, and the last in March 1963—metropolitan areas which show increases in general population and in unmarried mothers without comparable expansion of services to meet the latters' needs. The participants—a total of 145 at the meetings—included representatives of public and private adoption services, maternity homes, multiple service social agencies, health departments, hospitals, visiting nurse associations, and other health services, school systems, probation departments, and schools of social work.

Some of the blocks to improved services identified at the meetings involved: the problem of the rights of parent versus rights of the child; disagreement on the agency role in accepting voluntary surrender of the child from the mother; variations in the ways minor unmarried mothers are encouraged to exercise their rights to consent to adoption; residence requirements and other restrictions on eligibilty for service, particularly for financial assistance and medical care; and the inhibiting effect on planning of the lack of information on unmarried motherhood—a lack attributed mostly to agency compliance with these mothers' need for anonymity.

Most of the proposals for action that came out of the sessions centered on research and experimentation: in the causes of illegitimacy and ways of reaching unmarried mothers early in pregnancy; on experimental adoptive placements of children from minority groups with persons of other races, and of seriously handicapped children; on services to unmarried fathers. Still other proposals were related to planning for full use of Federal and State resources in the fields of family services, health, mental health, corrections, and welfare; the availability of Federal funds for program development by private agencies; the possibility of carrying out workshops or other projects for development of staff to work with unmarried mothers.

Research

A study has been launched in Prince Edward County, Va.—where public schools were shut down 4 years ago to avoid court ordered racial desegregation—by a research team from Michigan State University to determine the effects of the public school closure on children thus deprived of schooling. The project, which began last spring and will continue through the end of June 1964 under a contract carrying a $75,372 grant from the U.S. Office of Education, is being carried out primarily by graduate students in psychology.

Correction

A footnote mistakenly appeared on page 147 of the July–August 1963 issue of CHILDREN accompanying the article by Marguerite Q. Grant and Martin Warren. The footnote, which referred to a project supported by the Vocational Rehabilitation Administration, correctly reappears in this issue accompanying the article on hemophiliacs on page 189.

READERS' EXCHANGE

CHILMAN AND KRAFT, AND HILL:
What about the fathers?

I was interested to note that in their article, "Helping Low-Income Parents: I. Through Parent Education Groups" [CHILDREN, July–August 1963], Catherine Chilman and Ivor Kraft discuss only briefly the environmental conditions of life of low-income parents. This is probably as it should be, for I believe efforts to help such families have been hindered as much by stereotyped predispositions as by insufficient information about the lower class. The authors wisely counseled parent educators to learn directly from low-income family members what is important to them—in other words, to accept the low-income mother as a person before attempting to change her behavior.

I was glad to see the authors gently lay to rest arguments about which academic discipline is best, and to find that they were unconcerned about the social class origin of persons who teach in parent education so long as they are flexible, perceptive, and competent.

In general, the discussion by Drs. Chilman and Kraft revolves around three themes: (1) low-income parents are a withdrawn people to whom one must reach out more than halfway; (2) low-income parents are an unsure people who must be taught, shown, and supported in specific and concrete ways; (3) low-income parents are a diversified people who must be reached through a variety of approaches. But probably its most significant contribution is its strong emphasis on *how* these things are being done.

Director M. Esther Hill of the home economics education division in the Philadelphia schools presents an excellent illustration of how these themes have been structured into an ongoing program in a specific locality. ["Helping Low-Income Parents: II. Through Homemaking Consultants."]

As exciting as the programs described in these articles are, one still wishes that methods had been found to reach

fathers in the families. In Philadelphia, for example, fathers were present in two-thirds of the families referred to the service, but there was no mention in Miss Hill's article of any contact being made with them. Similarly, after talking with more than 60 persons associated with parent education projects throughout the Nation, Drs. Chilman and Kraft could only report that "experimentation to find ways of reaching fathers is under way in some agencies."

Let us hope for articles on how to help the low-income father.

Dr. Charles V. Willie
Research Director, Washington Action for Youth, Washington, D.C.

Similarities in parents' groups

The two articles which appeared in the July–August 1963 issue of CHILDREN under the title "Helping Low-Income Parents" provide an occasion for us to reexamine a number of issues involved in serving disadvantaged families by means of education for child rearing and homemaking.

One of the first issues raised in the article by Drs. Chilman and Kraft is the social class bias which some people believe has characterized family life education. While the Children's Bureau survey they describe failed to uncover many educational programs, per se, for low income parents, it should be remembered that a very significant form of parent and homemaking education has been provided such families by public health nurses and staff members attached to the community health centers many of these families frequent. The criticism that "the people who need it the most don't get it" is more appropriately leveled within than between groups. If we permit the mistaken idea that people in disadvantageously social and economic situations are unacquainted with educational efforts aimed at improving the "physical, emotional, social, and economic life of the family," we are in danger of jeopardizing future educational endeavors by instilling inappropriate expectancies in persons being trained for this work.

Not only has work already done with inner-city, low-income families revealed substantial eagerness to learn, but also an essential similarity of interests with regard to education for child rearing. About 2 years ago we compared the expressed child-rearing interests of a large group of suburban middle-class parents with those of a very low-income, poorly educated group of parents living in the city slums. Virtually no differences were found between the two groups in ranks assigned to the 10 most popular topics. Therefore, it seems inappropriate to emphasize the differences between the concerns of parents who represent varying social, educational, and economic levels. Rather, we can intensify our educational work fortified by the fact that our message is a relevant one.

We would also underscore the fact that the mark of a good program is *not* the size of the audience, and that those parents who resist all efforts to involve them in a group educational experience and whose neighbors describe them as desperately in need of this kind of help are probably incapable of profiting from a program of this sort. For such parents we must continue to provide help on an individual basis. It is essential that those who would provide education for child rearing and homemaking appreciate the remarkable opportunities which await them while recognizing the distinct limitations which are a function of the methods they must employ.

Armin Grams
Head, Parent Education Program, Merrill-Palmer Institute of Human Development and Family Life, Detroit, Mich.

DRUGS AND ACCIDENTS

The statistics on childhood accidents on page 245 of the November–December 1962 issue of CHILDREN lead me to call attention to a question of some concern. How important is the role of maternal drug intoxication in accidental death and injury of infants and young children in and around the home? When I recently broached the subject to a group of pediatricians, they did not know of any research on the subject and agreed it was an important one for investigation.

I have direct and indirect knowledge of several examples. In one instance, the mother under the influence of 4½ to 6 grains of Seconal dropped a baby, fortunately with no serious result. At the hospital the family physician, diagnosing the mother's condition as emotional shock attributable to the child's accident, gave her a drink of whisky.

If I were to estimate the relative importance of intoxicants in such accidents, I would place alcohol first; then in descending order, tranquilizers, barbiturates, and narcotics. "Addictive doses" of these drugs are hardly necessary to produce the little impairment of coordination and judgment that result in an otherwise avoidable accident at home or behind the steering wheel.

Admittedly, diagnosis of the drugged mother's condition after such an accident is difficult because of her obvious emotional reactions to the child's injury. But it is more likely if the physician is alert to the possibilities. If habitual or addictive use of drugs was established, the mother might be induced to accept psychiatric treatment for her underlying personality problems. Her guilt feelings about the accident could be used to overcome resistance to treatment.

I would like to see a psychiatric multidisciplinary research team provide 24-hour-a-day coverage of the emergency services of a large hospital for several months. Everybody involved in every accident would be studied as thoroughly as possible on the spot. Followup would be provided as indicated. Such research obviously could supply answers to many questions about accidents.

H. Robert Blank, M.D.
Associate Clinical Professor of Psychiatry, Albert Einstein College of Medicine, New York

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For Parents

DIAGNOSIS: EPILEPSY; a guide for parents. Jacqueline T. Leonhard. Parents Committee on Epilepsy, Family Health Association, Cleveland, Ohio. 1962. 39 pp. 50 cents.

THE GREATEST ROLE IN THE WORLD. Prudence Hamilton. Vantage Press, New York. 1962. 107 pp. $2.95.

Written for mothers, by a mother, with emphasis on the child's psychic health and well-being.

PARENTS ASK. Frances L. Ilg and Louise Bates Ames. Harper & Bros., New York. 1962. 425 pp. $5.50.

Based on suggestions offered in reply to letters received during the past 10 years from parents seeking advice concerning behavior problems in children under 10.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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INFANT CARE. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 8. 1963. 108 pp. 20 cents.

Addressed to parents, this 11th and entirely new edition of the Children's Bureau's bestseller since 1914 presents up-to-date information on the care of infants from birth to 12 months. It was prepared with the help of nearly 100 persons including specialists in the fields of psychiatry, psychology, pediatrics, orthopedics, nutrition, and parent education.

Appendices include among other items discussions of: special problems, such as care of the premature or handicapped infant; preventing disease and accidents; the care of the sick baby; infant diseases and disorders; and emergencies.

PRENATAL CARE. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 4. 1962. 92 pp. 20 cents.

This 5th edition of the Bureau's publication for expectant parents, including fathers—first issued in 1913 and last in 1949—presents information on the physical and emotional changes that take place during pregnancy and childbirth and offers advice on the care of the mother and preparation for the newborn. Throughout it stresses the importance of medical care during pregnancy and of including each family member in the preparations for the new arrival.

CREATING EXPERIENCE OPPORTUNITIES FOR YOUTH—to achieve a more responsible role in society for self and social identity for realizing American goals. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 102 pp. Single copies available from the Bureau without charge.

This is a report of the Joint Conference on Children and Youth, held in Washington, D.C., April 10–12, 1962, sponsored by the National Committee for Children and Youth, the Council of National Organizations for Children and Youth, the National Council of State Committees for Children and Youth, and the Federal Interdepartmental Committee on Children and Youth as followup of the 1960 White House Conference. (See CHILDREN, July–August 1962, p. 163.)

It presents summaries of the major speeches and roundtable discussions and extractions from reports of the national organizations concerning their respective programs since 1960. Appendices include the conference program, a brief description of the conference planning, and summaries of the biennial meeting of the Council of National Organizations and of the annual meeting of the National Council of State Committees.

INSTITUTIONS SERVING DELINQUENT CHILDREN; guides and goals. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 360. Revised 1962. 141 pp. 45 cents.

A revision of a 1957 document prepared in cooperation with the National Association of Training Schools and Juvenile Agencies for the staffs of institutions for delinquent children and other agencies and officials in the correctional field, this publication discusses the philosphy of institutional administration; the physical plant; and the major aspects of the treatment program, including individualized services, special institutional problems, and preparation for the child's return to the community and aftercare supervision.

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